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OBSTETRICAL COMPLICATIONS
Their Management Today and Twenty Years Ago*

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In 1931, twenty-two years ago, the author, a third year medical student at the University of Virginia, began the study of obstetrics under the late Dr. Tiffany J. Williams. Later he returned to the University of Virginia Hospital to complete a residency in obstetrics and gynecology under the same leadership. Dr. Williams was not only a great teacher but also an excellent clinician who kept abreast of new knowledge and applied the same with sound judgment.

It is the purpose of this paper to show a comparison in the management of some obstetrical complications as taught to me over 20 years ago and our method of management of similar conditions. These teachings are taken from my recorded notes and recollections when a medical and postgraduate student.

One must remember that 20 years ago there were no sulfonamides, no antibiotics and no blood banks. The application of these drugs and a more liberal use of blood has practically eliminated puerperal infection of types so commonly seen and dreaded in the past. The Rh factor was unknown and many a violent and occasional fatal reaction was the result of Rh-positive blood being given to a sensitized Rh-negative female. The active principle of ergot, ergonovine, was not available. The use of spinal anesthesia in obstetrics was considered heresy except by Dr. Cosgrove and his group at the Margaret Hague Hospital.

It is also true that two decades ago the majority of patients with both normal and complicated pregnancies were delivered in the home, often being admitted to the hospital only as a last resort or in extremis. Fortunately, today the majority of deliveries occur in a hospital where facilities are usually adequate and properly trained personnel are available for complications.

Let us then consider a few of the most common complications in obstetrics and compare their management of yesterday and that of today.

THREATENED ABORTION

It has been conservatively estimated that one out of every 10 confinements ends in spontaneous abortion. My notes read, "Threatened abortion should be treated by rest in bed with the foot of the bed elevated, heavy doses of sedation and an ice cap on the lower abdomen if the uterus is hyper-irritable. Palliative treatment should not be kept up too long; if the patient is still bleeding at the end of 14 days, allow her to get up with the hope that abortion may occur."

The magic formula for the prevention of abortion in the past 20 years has been vitamins and endocrines. First, we were told that a lack of vitamin E was causing abortions and wheat germ oil was literally poured into our patients. Other vitamins have been implicated and likewise used to an excess. Next, progesterone became the wonder drug and marvelous results were obtained with infinitesimal doses. Then came the era of estrogen or stilbestrol, and, finally, a combination of both estrogen and progesterone. Today, one is not at all certain that any of these hormones or vitamins are specific in the treatment of threatened abortion.

Several years ago Colvin[1] made a study of 1570 cases of threatened abortion occurring in the private practice of his group. None of these patients received any specific treatment. Seventy per cent went on to term and delivered a normal infant. In those who aborted careful examination of the prod-

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ucts of conception revealed that only 62, or 3.9 per cent of the total cases of threatened abortion could have been theoretically salvaged by hormone treatment. The remainder had blighted products of conception or anomalies of the fetus and secundines which were incompatible with life.

We have formerly used heavy dosage of estrogen in the management of threatened abortion, and we sincerely doubt today that they have been of any value.

Our management is essentially that of 20 years ago, namely, the patient who threatens to abort is advised to rest in bed for several days and if bleeding and cramps do not cease, she is advised to get up and move around. We believe that most of these pregnancies are abnormal and the sooner the uterus is emptied the better. It is perhaps true, as Colvin has pointed out, that hormonal treatment may be of some value in less than 4 per cent of all threatened abortions. To treat all threatened abortions with endocrines and vitamins in order to salvage 4 per cent seems wasteful, expensive and time consuming. Only when hormonal assays can be made and a deficiency demonstrated would it seem wise to administer endocrines.

ECTOPIC PREGNANCY

Thirty-two women died in North Carolina during the past five years because the diagnosis of ectopic pregnancy was not suspected. We were taught to be ectopic minded, treat shock and operate. There has been no change in the management of ectopic pregnancy; once the diagnosis has been made or suspected, operation is imperative. We do not hesitate to operate upon these patients in shock provided blood is available and running in the veins. Valuable time and blood may be lost in attempting to restore normal blood pressure and often this delay may prove fatal. Having observed the work of Allen and his group at the Presbyterian Hospital in Chicago, we have recently attacked the problem of ectopic pregnancy by the vaginal approach. Utilizing a good posterior colpotomy for suspected ectopic pregnancy, we have been able to visualize both tubes and ovaries in the majority of patients. In the past six months we have done 8 colpotomies when ectopic pregnancy was suspected. The diagnosis was positive in 5 patients and the pathological tube was removed per vagina in 4 cases. The fifth patient required a laparotomy because of extensive adhesions. In two patients the adnexa were normal and in a third patient pelvic inflammatory disease was present. These last three patients were spared a laparotomy and were discharged from the hospital on the third day.

By this means of positive approach to the diagnosis of suspected ectopic pregnancy we no longer explore the abdomen for our diagnosis nor do we wait for the classical signs of ruptured ectopic pregnancy in those suspected cases. The patient's hospital stay has been definitely shortened and the morbidity has been decreased.

TOXEMIA OF PREGNANCY

Volumes have been written and a great deal of research has been done on toxemia of pregnancy since 1931, but the etiology remains unknown. New drugs have been tried and old ones re-evaluated but as yet we have no specific therapy for this condition. Toxemia is still the leading cause of maternal deaths. Cosgrove[2] has pointed out that the management today is essentially that of yesterday and consists of three phases: (1) prophylaxis, (2) treatment of the symptoms, and (3) termination of the pregnancy.

Great progress has been made in the prevention of toxemia of pregnancy; more women are receiving prenatal care than ever before. With proper diet, weight control, restriction of sodium and correction of anemia, many of the toxemias of pregnancy are eliminated.

The patient with signs and symptoms of toxemia, no matter how mild, should be hospitalized for proper evaluation and treatment. The term "mild pre-eclampsia" is only relative and can often proceed quickly to eclampsia. We admit all our patients to the hospital when the blood pressure becomes elevated in the third trimester to 140/90 or above, or those who show 1+ or greater amounts of albuminuria on a clean or catheterized urine specimen. We believe the risk is too great to attempt to control these signs on an out patient basis. The management of toxemia of pregnancy in the North Carolina Baptist Hospital is bed rest, high protein, salt-free diet, sedation, careful check on the intake and output of urine, frequent blood pressure determinations and daily urinalyses. Blood chemistry studies are made, but, except for uric acid findings, these have been of little clinical value. For sedation we prefer phenobarbital, morphine and magnesium sulfate. The dose of these and other drugs must be individualized.

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The third phase in the management of toxemia is interruption of pregnancy which removes the one etiological factor that is always present. A decision as to when and how to empty the uterus is one of paramount importance and requires good obstetrical judgment. Dr. Williams was an advocate of conservative treatment in the management of toxemia. He realized, however, as we do today, that the longer the toxemia exists the greater the chances are for the patient to have residual hypertension and that the duration of toxemia is definitely related to fetal survival. In the interest of both mother and child pregnancy is interrupted at 34 to 36 weeks if the toxemia has been present for three weeks or longer. Severe pre-eclamptics in the late weeks of pregnancy not responding to treatment, and eclamptics whose convulsions have been controlled for a period of 24 to 48 hours, should have the uterus emptied in the safest and easiest manner.

Twenty years ago the Voorhees' bag was commonly used as a method of inducing labor. Brame,[3] in an analysis of 112 eclamptics at the University of Virginia Hospital from 1925 to 1934, found a maternal mortality of 50 per cent. Bags were used 32 times as a means of induction with six deaths, an incidence of 19 per cent. A comparative series of 114 eclamptics from the same institution has been collected by Thornton.[4] These cases cover the period between 1939 to 1949. No bags were used in this series and there were only seven deaths—an incidence of 6.1 per cent. Thornton has informed me that to the best of his knowledge no bags have been used for any obstetrical procedure in the past 10 years. We believe that Voorhees' bags have no place in the armamentarium of the obstetrician of today and should be relegated to the past.

Provided the patient is near term and the head is engaged, the easiest and simplest way to induce labor is artificial rupture of the membranes. This procedure should be done only if the cervix is favorable or "ripe", meaning that it is 50 per cent effaced and 2 to 3 cm. dilated. If these conditions are not present, we[5] have found that the administration of intravenous Pitocin is a valuable aid. We use 5 minims of Pitocin in 500 cc. of 5 per cent glucose in water. The administration is begun with 9 to 12 drops per minute with the patient under constant observation; the blood pressure, fetal heart rate, intensity and duration of the uterine contractions being carefully observed and recorded. It may be necessary to repeat this procedure for several consecutive days before the cervix becomes favorable or spontaneous labor begins. This procedure carries the inherent dangers of (1) elevating an abnormal blood pressure to dangerously high levels, as reported by Jackson and Decker.[6] We have constantly been on the alert for this possible pressor effect of Pitocin and have had no cases to date; (2) a prolonged or tetanic contraction of the uterus may occur and cause fetal death; (3) the greatest hazard is that of causing a ruptured uterus. Realizing that these accidents do and can happen, intravenous Pitocin should never be administered except in a hospital and with the patient under constant observation.

If the cervix is not favorable for artificial rupture of the membranes and intravenous Pitocin fails or cannot be properly administered, abdominal delivery by cesarean section under local anesthesia is the procedure of choice. The abdominal approach should also be used when immediate delivery seems imperative as, for example, the fulminating type of toxemia or the onset of oliguria and anuria.

ABRUPTIO PLACENTA

Dr. Williams taught: "The uterus should be emptied as soon as possible with acute hemorrhage, preferably delivery is done from below. One should make certain after delivery of the infant and placenta that the uterus contracts firmly. If it does not, bleeding may have occurred in the uterine musculature and will then require hysterectomy. In minor cases, watch the patient closely and be ready to operate if necessary. Existing shock must be treated and match blood in any bleeding case and be ready to transfuse if necessary."

In the management of abruptio or premature separation of the placenta there seems to be a definite swing today to the conservative side; as a result, less cesarean sections are being done for this condition. There are, however, two definite schools of therapy. The radical favor termination of these pregnancies by immediate section in the interest of both mother and child. The more conservative advocate induction and stimulation of labor with a vaginal delivery. We would classify ourselves as neither extremely radical nor conservative. We base our therapy on the severity, the type of cervix present and the condition of the infant. Acute hemorrhage which is not successfully combated with transfusion, a long firm cervix which will prolong labor, and associated tox-

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emia with beginning oliguria and anuria are indications to us for cesarean section. We have done cesarean sections in the interest of the child but doubt very much that it has improved our fetal salvage.

PLACENTA PRAEVIA

My notes read: "Empty the uterus immediately if the diagnosis of placenta praevia is made. If it is marginal or partial in type, do this from below with rupture of the membranes and distension with a Voorhees' bag; then deliver the child by version or forceps. With central placenta praevia, do a cesarean section if the baby is alive; if the baby is dead and the cervix is dilated, do a Braxton-Hicks' version."

Dr. Williams,[7] in his last paper, written before his untimely death in 1947, outlined a treatment for placenta praevia which was different from his teaching 15 years prior. The dictum to always empty the uterus with praevia was temporized with that of an expectant attitude provided the infant was too small to survive and labor had not begun. Pelvic examination was often omitted in the examination and when thought to be necessary, it was done as gently as possible. The patient was kept under constant observation in the hospital or nearby, and no effort was made to deliver the infant until it was near term or excessive bleeding intervened.

We believe that all patients with bleeding in the third trimester of pregnancy should be admitted to the hospital. Immediately on admission, before any examination is made, blood is typed and cross matched, with 1000 cc. or more being made available. If the child is small and bleeding is not excessive, we carry out the expected treatment with the patient under observation. However, if the patient is near term, or bleeding profusely, she is immediately taken to the operating room where arrangements are made for a sterile pelvic examination to be followed by cesarean secretion, if necessary—the so-called two-way set up. If the pelvic examination reveals the cervix partially effaced, 2 to 3 centimeters dilated, and no central placenta praevia, the membranes are artificially ruptured with delivery anticipated from below. Should the placenta be completely over the internal os, or if the cervix is unfavorable for a short easy labor, immediate cesarean section is done.

We do not believe that version and extraction has any place today in the management of placenta praevia. The complications occurring from this procedure are too common to be ignored. Especially is this true when the lower uterine segment is occupied by the placenta, and the tissues have a consistency resembling wet blotting paper. Is it surprising, then, that rupture of the lower uterine segment or laceration and infection, either of which may cause death to the mother, occur frequently?

A word in regard to the place of version and extraction in present day obstetrics: Keetel and Crelock[8], after a survey of this procedure at the University of Iowa Hospital over a 15 year period from 1936 to 1951, came to the conclusion that there was little indication except for (1) prolapse of the cord in a vertex presentation with complete cervical dilatation and the presenting part above the spine; and (2) a second twin presenting as a transverse.

Formerly we advocated version and extraction in face and brow presentation which could not be converted to occiput or chin anterior position. After several near maternal fatalities, including one ruptured uterus occurring in the hands of an experienced version operator, we no longer believe this is the proper procedure, and recommend instead cesarean section.

In a four year period from 1944 to 1948, there were 4,370 deliveries in the North Carolina Baptist Hospital with 22 versions, an incidence of 0.5 per cent. From 1949 to 1952, another four year period, there were 5,113 deliveries with 10 versions, an incidence of 0.17 per cent. Too many versions are done in our state by an operator who is not capable of performing cesarean sections and selects this formidable procedure as a method of delivery. This is well known by the fact that 20 maternal deaths have occurred in the past five years in North Carolina which are directly attributable to a rupture of the uterus following version and extraction. It is impossible to estimate how many patients have survived this procedure only to become gynecological cripples.

That the fetal mortality is definitely high in version and extraction is well demonstrated by a composite study from the New York Lying-In Hospital[9], Cook County Hospital[10], and Chicago Lying-In Hospital[11], of fetal mortality in relation to the type of delivery. Among 68,857 viable deliveries there were 2,732 fetal deaths. Version and extraction was performed 536 times with 139 fetal deaths, an incidence of 26 per cent, which was the highest incidence for any type of delivery. Cesarean section of low cer-

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vical or extraperitoneal type with the added protection of sulfonamides, antibiotics and blood is a much safer operation than it was 20 years ago both for the mother and child and should eliminate the use of version and extraction in the majority of obstetrical complications.

POSTPARTUM HEMORRHAGE

In the management of the third stage of labor, my notes read: "Following expulsion of the child, the uterus rises to above the umbilicus indicating the placenta has separated. A Crede maneuver (four fingers on the posterior surface of the fundus and the thumb on the anterior surface) is now done with gentle massage. If hemorrhage should occur right after childbirth, the maneuver is started at once. It is best to wait one hour longer for the placenta to separate before manual removal is performed. If a portion of the placenta is retained, watch the patient closely and do not invade the uterine cavity at once but trust it will be spontaneously expelled. In the case of severe bleeding after expulsion of the placenta, the patient should receive Pituitrin and ergot, shock must be treated and, if the bleeding is not controlled, pack the uterus."

We no longer teach or practice the Crede maneuver. Squeezing the uterus and exerting downward pressure often causes damage to the uterine musculature resulting in atony and hemorrhage, and often the products of conception are retained. It was common practice two decades ago never to invade the postpartum uterus except for hemorrhage. Today many of us remove the placenta manually if it has not spontaneously separated in 20 minutes or at any time if bleeding is excessive. Much blood can be lost during the waiting period and if not replaced the patient's resistance is lowered and infection is common. It is the purpose of manual removal to prevent this. We do not advocate this procedure in the hands of the inexperienced. With proper technique and aseptic precautions our morbidity has not been increased; we have saved blood and convalescence has been normal.

If a portion of the placenta has been or is thought to be retained, we do not hesitate to explore the uterine cavity immediately. Retention of products of conception invites infection and/or hemorrhage. The latter may be delayed for hours or days.

Excessive bleeding which occurs after expulsion of the placenta is best controlled by bimanual compression of the uterus with one hand in the vagina and the other on the abdomen. This is well illustrated in Eastman's[12] recent edition of William's Obstetrics. In some cases placing the entire fist in the uterus and compressing with the other hand on the abdomen will aid the uterus to contract. Oxytocics are immediately administered. All blood lost in excess of 500 cc. should be replaced by transfusion. We have seldom found it necessary to pack the uterus, and agree with Cosgrove[13] that it is an unphysiological procedure.

The best treatment for hemorrhage is prophylactic, which begins during the prenatal period with proper care of anemia and diet. Slow delivery of the infant, as advocated by Dieckman[14], is of definite value. Correct management of the third stage of labor will lower the incidence of hemorrhage. We recommend the Brandt-Andrew maneuver with the vaginal examination, as recommended by Leff. This has recently been well described and illustrated by Savage[15].

HEART DISEASE

Dr. Williams said, "In general, the prognosis with heart disease is good as long as compensation is maintained and the myocardium is not severely damaged. Cardiacs, with the first delivery, do better if cesarean section is done. Cesarean section should also be done on those in failure, preferably under local anesthesia."

Authorities[16,17] now agree that cesarean section should never be done on a patient with cardiac disease except for an obstetrical indication. There is statistical evidence that emptying the uterus imposes a burden on the heart. More people die of congestive failure following cesarean section where work is excluded than after vaginal delivery. Hamilton and Thompson[18] found at the Boston Lying-In Hospital that the death rate was four times greater in abdominal than vaginal delivery. They also state that cardiac failure occurred seven times more often in abdominal than in vaginal delivery, and pulmonary embolism occurred twice as often. It has been shown that the cardiac burden definitely begins to rise about the fifth month of pregnancy with a normal lightening of the load during the last few weeks of pregnancy. This indicates that all surgery should be done before the fifth month. When the fifth month has been reached all efforts should be made to carry the patient to term, awaiting ameloriation of the cardiac load in the last month and deliver the patient per vagina. In the past six years we have had 96

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patients with cardiac disease in 8,490 deliveries, an incidence of slightly over one per cent. We have done no cesarean sections on this group. There have been two immediate deaths. One was morbid on admission and the other had congenital heart disease and died undelivered with a 32 weeks pregnancy because of sudden acute heart failure.

SUMMARY

No attempt has been made in this paper to discuss all the changes which have occurred in the management of obstetrical complications during the past 20 years. The control of infection with sulfonamides and antibiotics is familiar to all. Surgical complications have been omitted. Only heart disease is discussed among the medical complications. A brief attempt has been made to discuss some of the most common obstetrical complications, especially in regards to fetal and maternal mortality.

Little, if any, change is noted in the management of threatened abortion, ectopic pregnancy and toxemia. It is recommended that the Voorhees' bag be eliminated from obstetrics and that version and extraction be limited in its application. Expectant treatment should be carried out in placenta praevia and the uterus not emptied if the child is premature and bleeding is not excessive. The best treatment for post-partum hemorrhage is prophylactic. Excessive bleeding is best controlled by manual removal of the placenta, bimanual compression of the uterus and rarely uterine packing. Blood loss should always be replaced by transfusion. Cesarean section should not be done in cardiac patients except for an obstetrical indication.

These few changes we believe have helped to lower our fetal and maternal mortality and have proven beneficial to us.

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REPORT OF 700 CASES OF IRRITABLE COLON IN PRIVATE PRACTICE*

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My favorite teacher, Herbert F. West, of Dartmouth College, in the preface to his newest book, "Rebel Thought", wrote, "At Harvard University, as a graduate student, I was unable to write a single sentence that was my own, as every statement had to be backed by some authority or pedant, and, although this might be good enough for a master's thesis or even a doctor of philosophy's dissertation, it did little or nothing to advance my own intellectual progress . . .". Such is the way I feel about the majority of references in medical articles. There must be a room in the vast house of medical knowledge for an individual's observations and opinions without their having to be presented as in accord with or contrary to leading authorities. Let me warn you that if this paper needs more authority than the author can give it, it will have to go begging.

I wish to bring out in this paper, but not statistically, some of the things which I have learned from treating in private practice 700 individuals (not cases), each of whom had the irritable colon syndrome. I know of no condition which requires of the physician as much patience, time, understanding and courage—courage to stick by medical therapy, and courage to repeatedly and continually deny the patient's inevitable belief that he or she has something requiring surgery. Too many of these patients have been operated on already.

I have become concerned over the attitude on the part of some of our profession toward these patients and over their approach to this condition. I have heard all I wish to hear about these individuals having strong neurotic tendencies. That approach harms both the patient and the medical profession.

That is the attitude which makes the medical student turn the page, the intern turn to a psychiatric consultation, the resident turn up his nose, the practitioner turn to his next patient, the patient turn to a charlatan, and the charlatan turn to his calcium gluconate and parenteral estrogen. Once that approach has been decided upon, no further thinking from the patient's standpoint is possible, and the patient's symptoms are reduced to a list of complaints about which the doctor feels little responsibility. Consequently, the doctor goes about his profession in a sure and certain way since he has been able to reduce what should be disturbing and of concern to him to a bizarre situation of the neurotic's making. Thus the patient goes about his duties with the same complaints, the same fears, and the same disability he had when he first presented himself for help.

There are two ways in which individuals with the irritable colon syndroms have suffered at the hands of the medical profession. The first is by way of the aforementioned approach to them on the part of many doctors. The second is by way of mistaken diagnosis and, therefore, incorrect treatment.

Individuals in this group had been previously diagnosed as having cholecystitis, with or without cholelithiasis, chronic appendicitis, diverticulosis, diverticulitis, coronary insufficiency, pancreatitis, ovarian cyst, salpingitis, hepatitis, biliousness, "intestinal fermentation", "autointoxication", pericolic bands, adhesions, "locked bowels", nervous stomach, and peptic ulcer. Some were told that they were threatened with an ulcer, or that there was an ulcer, but that it was not demonstrable on X-ray. One man was told thirty-five years ago that he was threatened with an ulcer. His difficulty has continued and he has yet to develop a demonstrable ulcer or to develop an ulcer-like symptom complex.

Patients had received many types of medical and surgical treatment. Previous operations included cholecystectomy, appendectomy, gynecologic procedures, gastric operations, exploratory operations, and operative procedures to release adhesions and to cut pericolic bands. One lady has had adhesions released four times. Regardless of the type of treatment each patient whose treatment included bed rest was better after treatment, only to have the same old difficulty come back at some time after resuming activity.

I have read and have been told that these indi-

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viduals frequently are concerned because they feel that some evacuations are incomplete. When I have read and heard this I have inferred a strong implication that the patient is something more than neurotic to be so concerned. Let us face it. It is a well-recognized phenomenon that distention of the descending colon, sigmoid, and rectum, be they distended by fecal material or by absorbent cotton, causes the unpleasant symptoms of lassitude, apathy, irritability, anorexia, and headache. People who suffer from an irritable colon often do have incomplete emptying. Therefore, they are entitled to some concern over a situation which they know from the past will cause discomfort or pain. In the case of functional disease, as doctors, we cannot listen to only the complaints, which are important to us, but rather we must concern ourselves with what are the complaints which bother the patient. I have long since parted company with one of my medical school professors who told us that when a patient brings in a written list of complaints we could be sure that here was truly a well, but neurotic patient. To do that is to accept the individual neither as a human being nor as a patient. If complaints are severe enough for a rational person to write them, then no matter how we feel about them, we must see these people with the responsibility and concern which comes of placing ourselves in the patient's predicament. We can do nothing less. In this alone do we have the power to keep many thousands of patients away from quacks, unrecognized spas and the colonic irrigators.

I do not see these people as the neurotic, bowel-conscious and helpless individuals I have heard them described as being. I see them as the perfectionistic, driving, accomplishing, striving individuals so typical of America, though I will readily admit that often the striving is pointless and that their anxiety over a small failure is seen out of all proper perspective. Being perfectionistic and of a striving nature, very often they are totally incapable of focusing on the 98% which is perfect, but only on the 2% which is imperfect. This desire to do well or the fear of failing causes gastro-intestinal contractions, and this must be very common because all stage fright is felt in the epigastric region. Daily we use the expressions "intestinal fortitude", "stomach for it", and "guts". The ancient Greeks believed that the seat of the emotions was in the epigastrum.

Although these patients were this type of individual their difficulty appeared to be precipitated always by another of many stresses and strains being added to an already harassed and harried person. Moving the place of residence, a new baby, or a difficult visiting relative were often the final straws on the camel.

I mentioned my interest in this subject to a well-trained psychiatrist, and he reminded me of what I have heard many times—that the miser is a constipated man. I find it impossible to dismiss these 700 human beings with a wave of the arm, and the rather childish idea that as King Midas fingered his gold, so did his colon hoard feces, and, by constant miserly fingering, roll his feces into small pellets. In the first place, I cannot answer for the misers of history, but none of the constipated people in this group wanted their feces hoarded. In the second place, I have found irritable colons in very generous people. In the third place, there should be no place in the practice of medicine for any idea which so neatly dismisses peoples' complaints, and so completely clamps the lid on future thinking.

This, I have been told, is a disorder of civilization. Rather, I believe, is it a result of the frontier feeling plus the democratic belief that anyone can be president if he strives hard enough. I am sure that the reason for its low incidence among primitive people is because of their resignation to an established order of society. We begin almost at infancy to train our children in the competitive and striving way. Many an irritable colon was begun by the effect on a child of the daily elementary school drilling of that motto in large gold letters in the chapel—"Good, better, best, never let it rest, 'til your good is better, and your better best". We have no place in our working society for the happy man—or rather for the man who can say, "I have done all I feel like doing today—I am happy—the Hell with that extra ten dollars".

I cannot believe, as I know it is generally believed, that this condition results from the taking of laxatives and enemas. The majority of these patients did not take laxatives, and half of them did not have any bowel habit complaints. The idea of it being due to irritation is left over from the days when it was considered an inflammation of the colon. These patients showed no evidence of irritation, or of inflammation. They suffered from what appeared to be disturbed function due to autonomic inbalance, and they exhibited much other evidence of autonomic

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imbalance such as hyperhidrosis, easy flushing, cold hands, hypotension, and bradycardia. As more is learned of the disturbance in physiologic chemistry caused by emotional and personality factors, we may learn that this dysfunction can be chemically or hormonally corrected.

There are not different types of this, at least not among these patients, but rather different phases of the same condition. The amount of mucus, the type of stool, and the type of pain were ever changing factors in any one individual. Therefore, I find it hard to categorize these patients into types based on percentage of mucus production. In fact that would be truly pseudo-scientific.

I have been impressed also with the fact that none of these individuals had merely an irritable colon. All had evidence of other gastro-intestinal irritability, and many of a generalized individual irritability. It is of interest here that all of these patients exhibited a delayed cardiac sphincter opening time and many suffered ulcer-like and food-relieved pains with and without pylorospasms. Globus hystericus was a common complaint among these people—in some, the presenting complaint.

Much has been written about diarrhea in this type of individual. All of these patients received relief from their treatment, whether they had diarrhea, constipation, or no bowel complaints, and in all the treatment was identical. Enemas taken during bouts of diarrhea produced hard, scybalous pellets, so I am forced into the belief that their diarrhea resulted from there not being sufficient colonic mucus membrane with which the more recent fecal material could come in contact, resulting in insufficient water absorption to prevent diarrhea, and that the amount of available colonic mucous membrane was decreased by the presence of adherent pellets. Enemas resulted in a cessation of diarrhea in all of the patients who had it.

The patients included in this survey were hard working men, busy house-wives, or women who tried to have both a career and a family. They had suffered for months or years before seeking medical advice. The presenting symptom was usually abdominal pain. The pain was either a dull sensation of fullness or sharp colicky pain anywhere along the colon, but most frequently at the flexures and in the region of the sigmoid. The pain was intermittent, and often between episodes of severe trouble the patients were completely free of symptoms, only to have a recurrence after inadequate rest, excessive work, emotional stress and strain, or a combination thereof. Some patients were wakened at night by their pain. Some could trace the beginning of their trouble to childhood. All felt emotionally unstable, and more irritable after a recurrence had begun. There was not a constancy about bowel complaints in these patients, either as a group, or as an individual. Some had diarrhea, some had constipation, some had regular and normal evacuation of scybalous stools, and some had no bowel complaints at all. The majority described ever changing bowel activity and stool characteristics. A few individuals had no abdominal pain and had no bowel complaints. In these individuals the presenting symptom was irritability and instability, and all of these individuals had stools characteristic of this condition, but did not realize that there was any abnormality present.

All described what they considered to be excessive gas production, and a rapidly changing waist measurement. I have observed a 3½ inch difference in girth in 24 hours on one patient. No patient noticed this change in abdominal fullness during trouble-free periods.

All female patients had exacerbations at the time of their menstrual periods, and at the time of the menopause. Frequency and urgency were commonly associated symptoms in the female patients. Many patients had back pain, but this also was more common among the females. There were often various types of sexual difficulties present, impotence, frigidity and dyspareunia being the most common, but most patients had a disappearance of these complaints when their episode of colonic difficulty was over.

The vast majority of these patients suffered anorexia and weight loss. Most patients' pain was aggravated by eating, and particularly after eating onions, garlic, hot seasonings, and greasy fried foods. Those patients who had an associated ulcer-like syndrome, with or without pylorospasms, were relieved by eating. Cancerophobia was universal, easy fatigue the rule.

The most important historical information next to the type of abdominal pain is found in the bathroom experiences of these individuals. During periods of trouble it was useless for them to go to the bathroom unless they felt a strong urge to do so, because otherwise they would spend unsuccessful and frustrating minutes, hoping and straining. When

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the urge was sufficient to warrant a try, one of many things happened, and all individuals who had bowel complaints ran the gamut of these changing happenings. Sometimes a small amount of flatus was passed with complete loss of the previous urge. Usually, however, a few, small, hard pellets were passed and, although the individual felt full, and in need of more evacuation, none occurred. These patients then felt that this evacuation was inadequate, and their feeling in the matter was proven to be correct by the fact that a small (200 c.c.) plain warm water enema produced 10-30 more pellets. The returning water was perfectly clear, indicating that the water had not gone much beyond the sigmoid, and that the sigmoid, therefore, contained 10-30 hard pellets of stool.

On other occasions these patients would pass pencil, or ribbon stools. At other times the stool was large, and looked like a three dimensional jig saw puzzle, made up of many pellets of varying shades of normal stool color, pressed together, and fitted to make a mosaic-like cylindrical mass. This usually became homogeneous toward the tail, of smaller diameter, and of softer consistency.

A composite portrayal of these patients would show an active, quick, friendly, perfectionistic individual, who would be ahead of time for the appointment, who would be exceptionally well-groomed, who would have necktie ends the proper length, yet who would have the concerned expression of a person who was resigned to a fate of pain and discomfort or worse. The vital signs would be normal. The patient would be of any body build. The reflexes would be exaggerated, and the palms and axillae moist, about which the patient would apologize. The opening time of the cardiac sphincter would be above 30 seconds. The abdomen would be tender everywhere until care had been taken to gain the patient's abdominal confidence. Then there would be tenderness in any quadrant, but always along the route of the colon. Tenderness of an identical nature would probably be elicited in more than one place. In each tender area the colon would be palpable as a contracted, hard tube about ¼" in diameter. With care it would be discovered that the only tender structure was the contracted colon. Rectal examination would reveal nothing except very tight sphincters.

In none of these individuals did the laboratory indicate any inflammation. There was frequently an anemia, caused, I presume, by either disturbed absorption, or by decreased intake. The stools were blood-free. What X-rays were done revealed the usual radiographic picture of this syndrome. I believe it imperative that these patients not be submitted to the long, involved, expensive and often unnecessary work-up to which so many of them have been submitted.

The therapeutic regimen which effected the greatest improvement evolved through successes and failures on my part with these individuals. I have been convinced that the most important single factor in treating these people is a full and detailed explanation by the physician of the condition, and of what he hopes to accomplish. It is wise to spend enough time, usually an hour, to do this in such a way that the patient does not leave believing still that there is a cancer present, or that "It's all nerves", for to the average patient that is the same as saying that all of the complaints are completely imaginary.

It is important for the patient to understand why he or she should do each thing suggested by the physician, and how each will help the condition now already understood by the patient. In this discussion it is imperative that the patient be shown a more relaxed approach to life, with less emphasis on striving foolishly, and that the patient's stress-causing problems be reduced to their proper size. Warn each patient of the recurrent nature of this condition, and warn against impatience, and its resultant search for what seems to be more definitive therapy. It often became necessary to discuss the whole problem with members of the family, occasionally with business associates.

I have found it helpful not to ask about the patient's stool characteristics, but to wait until after the examination was finished, and then to preface the above-described explanation with a description to the patient of his own stool characteristics. It served to convince the patient that the suggested therapy was based on an understanding of the condition, and allayed the patient's fear that here again was a physician who would reduce real dysfunction to "nerves".

Equally important in the plan of treatment is adequate rest. I got best results by starting these individuals on two hours more sleep each night than they thought they needed. It is important that working men have a rest period before their evening meal. Those patients for whom alcohol caused no aggravation had a cocktail or two before dinner, both to

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delay dinner, and as a relaxing agent. Because of the never ending quality of housework, housewives were advised to create their own end points, either by striving for less degree of perfection, or by declaring a certain hour to be theirs each day, and to spend that hour in some way which the average housewife of this group would think a selfish way —pursuing a hobby, or resting.

It became apparent with these patients that there was no need for a diet as long as each individual avoided the foods which caused distress. Coffee and tobacco were restricted in every case.

The only combination of drugs which proved to be of continued help was Belladenal, a mixture of phenobarbital and the levorotatory alkaloids of belladonna. All of the synthetic antispasmodics, and most of the barbiturate-belladonna mixtures on the market were tried. None was as efficacious as Belladenal. All patients were relieved by Belladenal, and, in all, the preparation brought about gastrointestinal relaxation without the necessity of its being pushed to the point of visual symptoms or of dryness. I feel that the reason for this is the fact that Belladenal contains a greater amount of the levorotatory alkaloids of belladonna than any of the others.

Methylcellulose was used in the earlier patients, but was abandoned for these reasons:

1. Most patients felt an increase in abdominal discomfort while taking it.
2. Many patients complained of large putty-like stool masses, which were difficult to pass, and
3. These patients' stools returned to normal without any bulk producing agent. Therefore, I find it hard to believe that such an agent is needed.

Each patient was asked to take a small warm water enema at the beginning of their treatment. Each was advised to take another enema on the second day of pellet-like stools. The majority of these patients have taken 1-2 enemas. None have needed more than an occasional one at the time of exacerbations. In none did the enema appear to cause any irritation.

Exercise was restricted during attacks because it was an almost universal observation on the part of these patients that exercise during an attack aggravated the condition.

Finally, one of the most important factors in treating this condition, I believe, is to get the patient out of the physician's hands as soon as possible. Most of these patients were seen three or less times. It is essential that they leave the office with enough understanding to treat themselves, to treat exacerbations and to prepare for trouble when something which might cause stress and strain appears on the horizon. Any additional advice needed can be given over the telephone. Only by such thorough understanding can the patient be ready to care for a condition which will be intermittently present for the length of time that this condition is usually present.

In conclusion, I wish to point out that here is a condition which challenges us, as physicians. Here is a disorder which requires skill, knowledge, ingenuity, and time not required by the majority of medical conditions. Here is an opportunity for the doctor to become a physician. Here is a chance for us to fight the quack and the charlatan in the way they should be fought—with the art, as well as the science of medicine as our weapons.

Summary

Personal observations on the diagnosis and treatment of the irritable colon syndrome have been presented.

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RECENT THERAPEUTIC AGENTS IN THE TREATMENT OF ANEMIA, WITH SPECIAL REFERENCE TO VITAMIN B-12*

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Several important drugs have been introduced in the last few years for the treatment of anemias. These are vitamin B-12, folic acid, cobalt, ACTH, cortisone, and saccharated iron oxide. It is the purpose of this paper to review briefly the use of these drugs, particularly as they apply to the general practice of medicine.

VITAMIN B-12

In 1926 Minot and Murphy[1] discovered liver therapy for pernicious anemia. Since then, investigation has continued in an attempt to find the factor in liver responsible for its therapeutic properties. Research was hampered by the lack of a suitable experimental animal as man was the only one who developed pernicious anemia. In this country Shorb[2] in 1947 found that liver extract was necessary for the growth of certain bacteria in culture media. This discovery subsequently led to the isolation of vitamin B-12 by Rickes *et al.* in 1948[3], using this microbiological method of assay. At approximately the same time Smith[4] in England isolated a red material by partition chromatography, subsequently identified as vitamin B-12. It is of interest that this discovery was made almost simultanously in both countries, in one by partition chromatography, and in the other by a microbiological method. West[5] found that vitamin B-12 was effective treatment for pernicious anemia in relapse. At the present time it is felt by most authorities that vitamin B-12 is the anti-pernicious anemia factor present in liver. Castle[6] has modified his previous theory concerning pernicious anemia as follows: vitamin B-12 is presently thought to be the so-called "extrinsic factor", and "intrinsic factor" present in the secretion of the stomach is necessary for the absorption of vitamin B-12 from the intestinal tract. Pernicious anemia is considered to be the clinical result of a deficiency of vitamin B-12. This deficiency is predominantly due to a lack of gastric secretion, itself usually a manifestation of heredity predisposition and advancing age.

Owren[7] and others[8] have cast doubt as to whether vitamin B-12 is as complete replacement therapy for pernicious anemia as liver. They found persistent macrocytosis and abnormal prothrombin concentrations in the blood of patients maintained on vitamin B-12. In 1948 the pernicious anemia patients of the Hematology Clinic at the Johns Hopkins Hospital were changed from liver therapy to vitamin B-12. In 1952 we published the results of this study of prolonged treatment of pernicious anemia with vitamin B-12[9]. A large group of patients with pernicious anemia had been maintained on vitamin B-12 alone for periods up to forty months. All of these patients remained as well on vitamin B-12 as on previous liver therapy. There were no hematological or neurological relapses. At the end of this study indices, smears, and prothrombin times were performed. No significant macrocytosis or abnormality of prothrombin concentration was found.

It was our opinion that vitamin B-12 was as effective as liver extract for producing and maintaining remissions in pernicious anemia. No evidence was obtained that anything other than vitamin B-12 was necessary. It had the distinct advantages over liver of absence of discomfort at the site of local injection, cheapness, assay by weight, and absence of allergic reactions which occurred in 20% of our cases at one time or another during previous treatment with liver.

It was found that the approximate parenteral dose of vitamin B-12 needed for maintenance therapy in pernicious anemia was 1 microgram per day, corresponding to one unit of liver per day. Patients who had obtained maximal neurological and hematological improvement were maintained in our clinic on 45 micrograms every six weeks. Larger doses were tried in cases with severe neurological changes without any demonstrable advantage over the above dosage. Initially, large doses, such as 30 micrograms twice a week, were often used until maximal clinical and hematological improvement occurred. A few patients were maintained on 150 micrograms every five to six months and apparently fared as well as the others. It was found with patients in relapse that the effective oral dose was approximately 100 times the intramuscular dose. If vitamin B-12 continues to be produced cheaply, adequate oral therapy

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may be possible in the future. However, in view of the data presently available it is felt that only parenteral therapy should be used with the exception of those engaged in research on this problem. Many claims as to the value of vitamin B-12 therapy in other diseases, such as osteo-arthritis, lupus erythematosis, trigeminal neuralgia, diabetic neuritis, herpes zoster, etc., have been made. However, it is beyond the scope of this paper to discuss the use of this material in these diseases.

Saccharated Iron Oxide

Saccharated iron oxide under the trade name of Feojectin, has been in use for the last five years[10]. This is the first effective parenteral iron that has been available, previous forms having either contained too little iron to be of value or were too toxic. However, its use should be greatly limited because only a rare patient with iron deficiency anemia needs parenteral iron. The vast majority of such patients respond satisfactorily to oral iron therapy. The body has no mechanism for ridding itself of iron except by the shedding of red cells. There is real danger of producing hemochromatosis by excessive parenteral iron. The indications for its administration are few. Ulcerative colitis and other gastro-intestinal diseases in which iron by the oral route would be contraindicated are the most frequent requirements for this drug. A rare case of iron deficiency anemia refractory to oral therapy may respond to parenteral iron. It may be needed in a rare case of iron deficiency anemia with pregnancy when oral iron is not tolerated. This material is expensive and when given intravenously, may cause alarming side reactions, and is a severe local irritant when extravasated. The dosage necessary in a given case may be calculated by a formula, and only the amount required to correct the deficiency should be injected. This formula is the hemoglobin deficit (normal hemoglobin—initial hemoglobin) x .255 = amount of parenteral iron needed in gms. This is a valuable new addition to our therapeutic armamentarium for use in the treatment of iron deficiency anemias when used correctly in properly selected cases.

Folic Acid

Folic acid has been used in recent years in the treatment of anemias. There are only a few well recognized folic acid deficiency states. These include some cases of sprue, nutritional macrocytic anemia, "pernicious megaloblastic anemia" of pregnancy, megaloblastic anemia of infancy, and some cases of megaloblastic intestinal "stricture" anemia. Patients with these diseases may respond to folic acid and not to liver or vitamin B-12. However, these conditions are so uncommon that they will rarely be encountered by the general practitioner. Folic acid can produce a hemopoietic response in pernicious anemia but does not protect the nervous system; therefore, it is contraindicated in this disease. On the other hand, folic acid has been incorporated into many of the multivitamin preparations now on the market. Conley and Krevans[11] have recently written that enough folic acid may be present in these vitamin capsules to relieve the anemia of pernicious anemia while the neurological disease may progress. They reported five cases of pernicious anemia seen by them with little or no anemia, and severe subacute combined degeneration of the spinal cord. These patients had received folic acid in multivitamin capsules, inadvertently prescribed in some of these cases by their physicians. It is felt that the practitioner should not prescribe such multivitamin preparations until he has at least assured himself that the patient does not suffer from pernicious anemia. Actually there is no reason for the inclusion of folic acid in such vitamin capsules in view of the danger of masking pernicious anemia and the rarity of true folic acid deficiency states. Probably folic acid should be restricted for use only in a pure form in the above indications. The dose used in the treatment of folic acid deficiencies is from 10-30 mgms. per day orally.

Cobalt

Cobalt therapy has recently been recommended for the treatment of anemias of infection, anemia of chronic renal disease with uremia, and other conditions. However, the evidence is not complete that cobalt is of value in these diseases, either alone or in combination with other agents[11].

Cortisone and ACTH

Cortisone and ACTH have produced occasional remissions in cases of acquired hemolytic anemia. A rare case of aplastic anemia has responded to these drugs.

Discussion

The well established principle of specific therapy for specific anemia still holds. Hardly a day passes that some drug salesman does not enter my office with a capsule containing liver, B-12, folic acid, and

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iron. Because of the rarity of true folic acid deficiency states and the danger of their use in unrecognized pernicious anemia, there is no need for the inclusion of folic acid in these capsules. B-12 or liver therapy in pernicious anemia should be given only by the parenteral route according to our present knowledge. Both are effective and nothing else is needed in cases of pernicious anemia and other related megaloblastic anemias that respond to these agents. Specific oral therapy with ferrous sulfate or ferrous gluconate is cheap and all that is necessary for the treament of iron deficiency anemias that make up the majority of cases of anemia encountered in general practice. In no other forms of anemia, such as aplastic, myelophthistic, hemolytic, etc., is the administration of any of these agents justified. Oral iron over a period of time in refractory anemia has recently been reported as causing hemochromatosis[12].

In closing, I would like to quote from a recent editorial by Wintrobe in the *American Journal of Medicine,* entitled, "Shotgun Antianemia Therapy"[13]: "There is no justification for indiscriminate medication and such a practice is obviously dangerous as well as unsatisfactory. There certainly is no need for symbolism or for mysticism. Yet, under the cover of euphonious names, the sales of these nostrums—the present day successors of the patent medicines of yesterday—total in the millions. It is implied that some mysterious beneficial effect will result from their use and that a subtle, ever present nutritional deficiency will be corrected. The valuable confirmation of the diagnosis which can be derived from the response to the specific therapeutic agent is lost while the cost of the antianemic therapy is multiplied ten or twenty-fold."

SUMMARY

Recently introduced drugs for treatment of anemias have been reviewed and their indications and uses defined. Specific therapy for anemia is still most advisable. "Shotgun Antianemia Therapy" has no place in the rational management of anemias.

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A REVIEW OF RECENT ADVANCES IN RADICAL PELVIC SURGERY— Report of Three Cases*

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Radical pelvic surgery reached a new peak with the report in 1948 of three cases by Brunschwig[1] in which he described an operation devised for the total excision of all pelvic viscera in mass for advanced carcinoma. His technique was that of a one stage abdomino-perineal operation with end colostomy and bilateral ureteral implantations to the colon above the colostomy. The main conclusion at that time was that the operation was compatible with normal physiological activity.

In 1949 Brunschwig and Walsh[2] reported block dissection of pelvic neoplastic tissue with the loss of the lower segment of the right common ileac vein, a great portion of the external ileac vein, and the hypogastric vein and its branches with only mild post-occlusion swelling which did not effect or delay the subsequent ambulation.

Bladder substitution was described by Bricker[3] following the above described radical pelvic surgery in which, due to the location of malignant tissue, the bladder had to be sacrificed. His suggested methods included: 1. Bilateral ureteral anastomosis to an isolated section of colon. 2. The use of isolated cecum as a reservoir with ureteral anastomosis and cecostomy for drainage to the outside. 3. Ureteral transplantation to the cecum (which served as a reservoir) and the use of terminal ileum for drainage to the outside, and, 4. Ureteral anastomosis to a segment of isolated ileum and an ileo-ileostomy performed to complete the continuity of the G.I. tract.

Again, in 1950, Brunschwig, *et al.*,[4] reported on radical surgery for carcinoma of the female genitals with bladder invasion but without involvement of the rectum. Here he advocated a total vaginectomy, total cystectomy, total hysterectomy, removal of all pelvic lymph nodes and bilateral ureteral implantation into the intact sigmoid colon. At this time in his report, which included 36 cases, he states that he had an overall mortality rate of 22% of operations performed.

Burt[5] reported a case of unassociated carcinoma of the rectum and carcinoma of the prostate. His procedure consisted of abdomino-perineal resection of the rectum, removal of the bladder, prostate and external genitalia en mass and bilateral anastomosis of the ureters into the sigmoid colon which was brought through a left rectus splitting incision as a sigmoidostomy just below the umbilicus.

The role of radiation therapy in conjunction with radical surgery for uterine carcinoma is discussed by Payne[6] who feels that surgery with complimentary radiation has increased the surgical survival rate in cases of corpus cancer. He also states that in cases of cervical carcinoma, primary radiation by external and local approaches remains the keystone of therapy, while the supplementary use of surgery has certain limited indications. He feels that for the present it is not wise nor humane to abandon the proved for the dramatic and unproved treatment measures.

Pre-operative artificially induced progestational state has been described by Cromer, *et al.*,[7] as facilitating surgery and reducing post-operative complications. This has been accomplished by the administration of large doses of progesterone pre-operatively. In 75% of the cases reported, which was 12 out of the 18, there was a varying degree of gross changes in the organs and tissues of the pelvis. These changes were not unlike those of early pregnancy, namely: 1. Increased vascularity of the organs of the pelvis. 2. Edema of the subperitoneal areola connective tissue which enhances the dissectors plane of cleavage, and, 3. Increased uterine and uterine ligament mobility. Cromer did feel though that the degree of response was subject to dosage, age, and the manner and method of previous irridation.

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Pierce[8] from Brunschwig's Clinic reports that they select their cases for surgery, taking into consideration coronary disease, hypertension, obesity, psychoses, malnutrition, etc. She feels that in the past her operative mortality rate had been pushed to a maximum by having disregarded such conditions. "In the early group of cases we occasionally proceed with exenteration in spite of perio-aortic nodes, knowing that we were leaving disease behind because those patients were either radiation failures or in extreme pain." In recent years it has been her policy not to proceed with an exenteration unless she was reasonably sure the gross cancer had been circumvented.

There have been three cases of radical pelvic surgery performed at the Jefferson Hospital in Roanoke, Virginia, since 1951. Each of these three were selected cases.

Case I. Mrs. B.W.T., a 36 year old white female, came to the hospital on 9-5-52 complaining of severe pelvic pain. The patient stated that she had had no symptoms until her present illness which began two weeks prior to admission with onset of pelvic pain, lower abdominal pressure, and low backache.

Physical examination was essentially negative except for the pelvic examination. There was a mass in the posterior vaginal fornix which seemed to be about 3 cm. in diameter and attached to the rectum. A biopsy was taken and this mass was reported as epidermoid carcinoma. The seriousness of the contemplated procedure was discussed with the patient. At operation on 9-8-52 there was no evidence of distant metastases. It was felt at this time the rectum could not be saved safely and it was decided to perform a total hysterectomy, removal of vagina, and abdominal-perineal resection of the rectum. The abdominal operation included appendectomy and bloc freeing of uterus, both ovaries, tubes, and freeing up of the rectum and the formation of a colostomy. The perineal portion consisted of removing this mass along with all of the vagina except a rim of tissue around the urethral opening. The patient at the end of the operation was in mild shock although she received 4 pints of blood in the operating room and had been prepared with 5 pints pre-operatively. She was discharged on the 22nd hospital day with a colostomy functioning properly, and her perineal wound healing nicely.

The patient was last seen several weeks ago and is entirely free of pain and there is no evidence of any residual malignancy. She is happy with the results of her operation.

Case II. Mrs. L.R.H.,[9] a 47 year old white female, was admitted to the Jefferson Hospital March 3, 1951, with a complaint of cramping pains in the lower abdomen of 18 months' duration. These symptoms had started about two months following a supravaginal hysterectomy for myomata uteri and had been progressively more severe. During the six months prior to admission she had had almost constant abdominal pain which had become increasingly severe and had required daily narcotics for relief of pain. Increasing dosages of narcotics had been taken, and it was thought by the referring physician that the patient was an addict at the time of admission.

Physical examination revealed moderate abdominal distention with intestinal patterns easily visible and marked voluntary muscle spasm throughout the lower abdomen. No definite mass was found on abdominal examination. On pelvic examinations, however, a hard, fixed, firm mass was found which had replaced the cervix and was extending slightly into the broad ligaments and superiorly into the floor of the bladder. Sigmoidoscopic and x-ray examinations were not satisfactory due to poor cooperation of the patient, but there was evidence of a partial obstruction in the sigmoid with marked dilatation of the small intestine. She was placed on sulfathaladine by mouth as preparation for colon resection, and two days before operation on streptomycin.

On March 9, 1951, the pelvis was explored. A hard carcinoma of the cervix was found which had invaded the urinary bladder and there was direct extension to the mid portion of the sigmoid which was attached in this area and also one loop of ileum which was almost completely obstructed. The ileum and sigmoid were each resected. The left ureter was tremendously dilated and both the left and right ureters went into the mass. It was necessary to transplant both ureters into the rectosigmoid below the sigmoid anastomosis. The lower 2-inches of each ureter was then removed along with the bladder, cervix, and what remained of the round and broad ligaments and pelvic peritoneum. No evidence of remaining malignancy was present grossly.

The patient was discharged on her 28th hospital day in an improved condition. She returned to the hospital on February 1, 1952, with complaint of vaginal bleeding. There had been a weight gain of

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50 pounds since surgery. Appetite had been excellent and she exhibited no difficulty in urinary control. Pelvic examination showed a little irregularity in the anterior wall of the shortened vagina. There were a few tiny non-visualized nodules which were difficult to decide whether they were recurrence of malignancy or unsatisfactory wound healing. The impression was possible recurrent carcinoma. Radium was placed into the vagina and she received 100 mg. of radium for 30 hours. She was discharged on February 4, 1952.

In October 1953, the patient was reported to be doing very well by her family physician.

Case III. Mrs. R.A.W.S., a 33 year old white female, was first admitted to the hospital on March 18, 1952, because of abdominal and vaginal pain of 6 months duration. Associated with this was a tumor of the vagina of one year's duration. The vaginal tumor gradually increased in size after onset and at the time of admission had almost completely filled the vagina. Six months prior to admission the patient had been given x-ray therapy at another hospital. Examination on admission revealed a pedunculated papillary tumor with smooth surface, so large that only one finger could be inserted into the vaginal vault. On rectal examination the uterus was thought to be free and of normal size. Biopsies taken from the tumor showed benign squamous papilloma. 100 mgms. of radium was inserted into the vagina and left for 15 hours.

The patient returned 5 months later and was admitted to the hospital. She stated that since her discharge her abdominal and vaginal pains have persisted and occasionally required narcotics for relief.

On rectal examination the tumor was very large and the cervix of the uterus was not definitely felt. Exquisite tenderness on pressure over the vaginal tumor was noted. At operation a portion of the tumor removed was reported as epidermoid carcinoma, Grade II and Grade III. The tumor appeared to invade the entire wall of the vagina with extension to the bladder and rectum, and involved the labia majoria on both sides extending through the vaginal vault and involving the cervix and under surface of the bladder. There was no evidence of distant spread. There were no glands along the iliac vessels or aorta nor any nodules felt in the general peritoneal cavity. A bilateral inguinal gland dissection, abdominal and perineal resection of the uterus, vagina, bilateral salpingo-oophorectomy, partial cystectomy, and partial excision of the rectum and appendectomy. This operation was performed by two teams working simultaneously, two surgeons above and two below.

Post-operatively the patient developed atelectasis and also developed a urethral and vesical fistula. She was discharged in a somewhat improved condition but was to return in two months for repair of the fistula.

She returned on 12-8-52 and underwent an attempt of closure of the vesical fistula. She was discharged and again requested to return for another re-check.

She was readmitted in March, 1953, for re-check and at this time she was found to have lost her urethral sphincter, which was causing her incontinence. There was no evidence of residual neoplastic tissue.

At the present time she is free of pain but uncomfortable because of urinary incontinence.

SUMMARY

1. A review of recent advances in radical pelvic surgery has been given with types of curative and palliative operations for the treatment of metastatic cancer of the pelvic organs.
2. A report of three cases of radical pelvic surgery at the Jefferson Hospital, in Roanoke, Virginia, has been given with a two and one-half year follow-up on one case and a one year follow-up on the other two cases.

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Jefferson Hospital.

Symptoms Blamed on Food Allergy.

All that itches is not allergy.

Although two or three out of every hundred persons have a serious sensitivity to food, many of the symptoms ascribed to allergy are not due to that at all, according to Dr. Samuel M. Feinberg, Chicago.

"There is a common notion that when any food does not agree with a person he is allergic to it," Dr. Feinberg wrote in the current Today's Health magazine, published by the American Medical Association. "This is far from correct. A large number of people have allergy to foods. Estimates of how many vary. Perhaps in two to three per cent of the population food allergy is more or less a major problem."

Many foods can cause irritation of the gastrointestinal tract or abdominal discomfort without being the result of an allergy, Dr. Feinberg pointed out. Allergy to foods will produce such symptoms as hives, eczema, asthma, nasal congestion and headaches.

Almost every food is at least potentially capable of causing allergy, although a relatively small number of foods are responsible in most cases. The more important causative agents are wheat, eggs, fish, nuts, peas, beans, potatoes, onions, garlic and milk. The amount of a food required to produce allergy symptoms varies considerably, he said, adding:

"The degree of sensitivity varies with different people and in the same person at different times. Fatigue, nervousness, tension, unhappiness, indigestion or certain phases of the menstrual cycle may lower the tolerance and make one more susceptible."

Allergenic properties also can vary with the state of the food, according to Dr. Feinberg. Cooking and canning tend to destroy some of this activity. Highly refined foods and those with little protein content are least likely to produce allergy symptoms.

"Since foods not only come in contact with the tissues of the digestive tract, but small portions of their allergenically active proteins are absorbed and finally circulate to every portion of the body, virtually no organ is exempt from possible reaction," Dr. Feinberg stated.

"But there is great danger in assuming that any ailment which cannot be explained otherwise is due to food allergy. The allergic person is as subject to other ills as the nonallergic person. Because a person happens to be allergic, it must not be taken for granted that his every ailment can be explained by the allergy."

If a patient's symptoms are caused by food allergy, the final goal is to determine the cause of the allergy, Dr. Feinberg said. Often the food can be identified by the patient, but in many instances careful inquiry by the physician may be necessary.

After the offending food has been determined, it should be eliminated as much as possible from the diet, or the intake reduced to quantities which may be tolerated without reaction.

Dr. Feinberg warned against "food fads" and "health crackpots" who claim elimination of certain foods from the diet will rid one of all types of food allergies. Such diets "frequently result in serious undernutrition and dietary deficiencies," he said, and may cause "underweight, weakness, fatigue, inability to concentrate, nervousness, irritability and growth disturbances."

Dr. Feinberg is chief of the allergy clinic and director of the allergy research laboratory at Northwestern University Medical School.

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MASSIVE HEMORRHAGE IN PEPTIC ULCER*

M. K. King, M.D.,
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Massive hemorrhage from peptic ulcer is a problem which occurs frequently in hospital practice, and which always represents a serious threat to life. The management of such patients is still somewhat of a controversial matter. I propose to show that the mortality can be reduced in these patients if from the beginning they are regarded as surgical emergencies and handled accordingly. In this discussion, I would like to differentiate clearly between massive and moderate hemorrhage. In mild to moderate hemorrhage, there is ample time to carry out a planned program of preparation for surgery; or in some cases, especially with the first hemorrhage, surgery may be deferred in favor of a program of medical care and observation. In massive hemorrhage, conservatism, procrastination and a "let's wait and see" program often leads to a fatal outcome.

One of our difficult problems in bleeding patients is to determine in the early stages the extent of the hemorrhage and whether or not it has ceased. Hemoglobin and red blood cell studies are of little value at first, because the blood volume diminishes in proportion to the blood loss. The blood volume is restored by plasma from the tissues, and twenty-four to forty-eight hours may pass before this restoration is completed; so the initial blood studies, including the hematacrit, may be normal even though the patient is in deep shock from hemorrhage. Blood volume studies have been of little value in our experience. Laboratory studies are of increasing value as the case progresses, but in the initial stages we must depend largely on clinical evaluation as to the degree and progress of the hemorrhage. A definite decision can usually be reached within twenty-four hours as to whether the hemorrhage is massive and continued, and whether the patient's life will be jeopardized by continued conservative treatment.

In the published reports on bleeding ulcer the mortality rates are sometimes misleading unless they are carefully analyzed. In Holman's[1] series of 161 conservatively treated patients, the mortality rate was 13 per cent, and this is about a fair average for reports from other writers. Holman's study was based on straight hospital admissions for bleeding ulcer, and represented all degrees of hemorrhage. In a later study, Holman stated that under conservative treatment, the mortality was 50 per cent in these two types of patients: "Namely (1) those who continued to bleed for twenty-four to forty-eight hours after they had been placed on a strict medical regimen, and (2) those who started to bleed in the hospital while under strict medical treatment for a heretofore uncomplicated ulcer."

Meulengracht's[3] report of 1 per cent mortality in 273 conservatively treated patients is frequently quoted, but his findings are at wide variance to other authorities such as Chiesman,[4] whose mortality rate was 25 per cent in 191 patients.

In this discussion, massive hemorrhage may be defined as hemorrhage sufficient to produce shock, and which continues twenty-four to forty-eight hours in spite of all treatment. If this type of hemorrhage is separated from the milder forms, the mortality rate will average 50 percent or above on conservative treatment. We have it within our power to reduce this mortality to a very low figure. We know that the hemorrhage can be stopped surgically, and we know that with few exceptions, the surgery can be done safely. Adequate blood replacement is the key which makes this possible.

Blood replacement should be in proportion to blood loss and should be rapid. 3000 to 7000 cc. of whole blood has been repeatedly given in a twenty-four hour period with no ill effect. It may be necessary to keep several transfusions going at the same time, using large caliber needles, 16-18 gauge, to restore the normal blood level. It is practically impossible for secondary and irreversible shock to develop if this plan is followed.

In the average patient with sudden hemorrhage, the protein, electrolyte and nutritional valves are within normal limits prior to the hemorrhage. When the blood loss is rapidly corrected, surgery is tolerated as well as in the patient who has had no bleeding. When surgery is delayed or where blood replacement is too slow, this is not true. The often heard proposition that rapid blood transfusion will increase the bleeding is open to considerable doubt and should be completely disregarded. Holman[2]

*Read before the annual meeting of The Medical Society of Virginia at Roanoke, October 18-21, 1953.

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states that there is no foundation for this assumption.

In all operations for the control of hemorrhage, it is of the utmost importance to establish the diagnosis, if possible, prior to surgery. Fortunately the diagnosis of ulcer has been established in most cases before the bleeding occurs. In those cases where the diagnosis is in doubt, it is not only permissible but necessary to carry out careful studies to establish the diagnosis. The danger of operating on an undiagnosed case is far greater than that incident to x-ray studies with barium, even when given in the presence of active bleeding. In making such studies an attempt should be made to evacuate clots from the stomach by Wangensteen suction, and all manipulations should be extremely gentle. If no ulcer is demonstrated, or if the cause of the bleeding can not be established, any surgery should be approached with caution. Exploration for undiagnosed upper gastro-intestinal bleeding may result in completely negative findings, as more than one surgeon has found to his embarrassment.

The discussion of gastro-intestinal hemorrhage from causes other than peptic ulcer will not be taken up here.

In considering the surgical approach to bleeding ulcer, we hope to achieve three things: (1) Immediate control of bleeding; (2) Prevention of future attacks of bleeding; (3) Permanent relief from ulcer symptoms. These results can best be achieved by a deliberate and carefully done subtotal gastric resection. This procedure controls the hemorrhage and offers a high expectancy of permanent relief.

Such operations as purse-stringing the ulcer bed, cauterizing the ulcer, ligating all adjacent vessels, gastro-enterostomy and vagotomy are dangerous makeshifts which frequently do not control the bleeding even temporarily, and offer no protection against future attacks. I have had the experience of watching an actively pumping arteriosclerotic vessel in the bed of an ulcer continue to bleed after all vessels in the area had been ligated, including the gastro-duodenal. The bleeding did not stop until the duodenum was dissected away and mattress sutures had been placed in the ulcer bed.

Abstracts from three recent cases of massive hemorrhage are presented to illustrate some of the points which I have outlined above.

Case 1. V. T., an obese white woman of 53 years, was admitted to the hospital on October 23, 1952, in mild shock. She gave a history of duodenal ulcer for eight years or more, with recurrent episodes of pain and bleeding. The diagnosis of ulcer had been confirmed on x-ray examinations. On the day of admission, she had had a fairly massive hemorrhage, with hematemesis and melena. The initial blood studies showed a red blood cell count of 1.8 million, hemogobin 4.5 gms. (29%). Since active bleeding had apparently ceased, she was placed on a moderately rapid blood replacement program of 500 cc. twice daily. Several moderate hemorrhages occurred thereafter, and on October 30, another massive hemorrhage developed. Preparations were started for rapid blood replacement and surgery. Her hemoglobin was now only 8 gms. (51%), although she had received 6,500 cc. of blood.

During the next twenty-four hours she received 4,000 cc. of blood, including 1,500 cc. in the operating room. At operation, a large posterior duodenal ulcer was found still actively bleeding. A high subtotal gastric resection was done, which she stood well. Her recovery was delayed by broncho-pneumonia which cleared up under antibiotics. She left the hospital on November 19, 1952, apparently recovered. The hemoglobin at the time of discharge was 12.5 gms. (80%); the red blood cell count was 4.97 million. While in the hospital, she received a total of 13,500 cc. of whole blood (twenty-seven transfusions of 500 cc. each).

Case 2. J. S., a white male of 29 years, was admitted to the hospital on April 25, 1953, after a moderate upper gastro-intestinal hemorrhage. He gave a history of having had a gastric resection for duodenal ulcer over two years previously and the present bleeding was presumed to be from a marginal ulcer. The blood pressure on admission was 110/60, pulse 88; hemoglobin 13.2 gms. (88%). Transfusion was withheld pending observation. On the following day, another hemorrhage occurred and transfusions were started. On the third day, a massive hemorrhage occurred. The blood pressure dropped to 70/50 and the hemoglobin 8.4 gms. (56%). He was started on a rapid blood replacement program and prepared for surgery. 7,000 cc. of blood were given prior to and during his operation on April 28, 1953.

The bleeding was found to be coming from both marginal ulceration and hemorrhagic erosions in the gastric mucosa. A very high gastric resection was done. He stood the operation well and recovery was uneventful. He was discharged from the hospital

on May 8, 1953, ten days later, in good condition.

Case 3. J. W., a white female of 38 years, was admitted to the hospital on September 17, 1953, complaining of severe upper abdominal pain. She gave a history of duodenal ulcer for thirteen years, which had recently become intractable to medical treatment. She was admitted for probable surgery, but there had been no history of bleeding prior to admission. On the day following admission, she had a massive hemorrhage and her hemoglobin dropped from 13.6 gms. to 8.4 gms. (55%), with a red blood count of 2.75 million. Rapid blood replacement with 4,500 cc. of blood were given up to and during the time of operation on September 20, 1953. At operation, a large actively bleeding posterior duodenal ulcer was found with the base of the ulcer formed by the pancreas. A high subtotal gastric resection was done. She stood the operation well and recovery was uneventful. She was discharged from the hospital ten days later in good condition.

SUMMARY

An attempt has been made to show that massive hemorrhage from peptic ulcer is a surgical emergency rather than a medical problem. The high mortality of 50 per cent or more which occurs on conservative therapy can be reduced to a very low figure if a program of rapid blood replacement and early surgery is carried out. These remarks are not intended to apply in mild to moderate hemorrhage.

Abstracts from three illustrative cases are presented.

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500 Wainwright Building.

Addition of Nutrients to Food.

In addition of specific nutrients to certain staple foods has been beneficial to the nation's health and has encouraged sound nutritional practices, the American Medical Association's Council on Foods and Nutrition has reported.

However, it stressed the desirability of the individual meeting his nutritional needs by the use of natural foods as far as practicable. People should learn, it was added, the proper choice and preparation of foods, and better ways to produce, process, store and distribute foods.

The council endorsed the enrichment of flour, bread, degerminated corn meal and corn grits; the nutritive improvement of whole grain corn meal and of white rice; the retention or restoration of thiamine, niacin and iron in processed food cereals, and the addition of vitamin D to milk, of vitamin A to table fats and of iodine to table salt.

"The principle of the addition of specific nutrients to certain staple foods is endorsed for the purpose of maintaining good nutrition as well as for correcting deficiencies in the diets of the general population or of significant segments of the population," it was stated by Dr. James R. Wilson, Chicago, secretary of the council.

"In order to avoid undue artificiality of food supply, foods chosen as vehicles for the distribution of additional nutrients should be, whenever practicable, those foods which have suffered loss in refining or other processing, and the nutrients added to such foods should preferably be the kinds and quantities native to the class of foods involved."

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NOTES ON PULMONARY TUBERCULOSIS*

Standard Diagnostic Study (I) Sputum Examination and X-Ray

Application of Standard Diagnostic Study methods by General Practitioners to confirm or exclude the presence of pulmonary tuberculosis is not too difficult when a few basic considerations are borne in mind:

Sputum examination is an obvious *first* thing to be done when satisfactory specimens are obtainable. Samples should be tested as soon as possible since recovery of Tubercle Bacilli from sputum (or gastric washings) provides the simplest and most conclusive proof of the presence of active tuberculosis in any person otherwise legitimately suspect. When negative, tests should be repeated time and again, at frequent intervals; cultures should be requested on each specimen whenever possible. The Virginia State Health Department regularly cultures, as well as examines directly, by "concentration" method, all such material submitted to its laboratory in Richmond. (By "concentration method" is meant microscopic examination of specially treated centrifuged sputum sediment).

Where resort must be had to culture, advantage should be taken of the intervening six to eight weeks usually required for a report, to perform the one or more *tuberculin tests* routinely indicated as a part of standard diagnostic study. When sputum is found laden with Tubercle Bacilli (acid fast bacilli), *early,* in the study, in a patient whose clinical condition is thoroughly compatible, tuberculin testing is optional and probably superfluous.

Although technique of gastric lavage is quite similar to and no more complicated than for ordinary gastric analysis there should be but few occasions where a patient need be subjected even to this relatively slight inconvenience, until his tuberculin status has been established. Rare indeed would be the indication for a gastric lavage in a person whose tuberculin tests had been negative through the higher concentrations. The latter, when negative, in and of themselves, for all practical purposes, rule out clinical tuberculosis, and other diagnostic possibilities should be further explored.

*Prepared by the Virginia State Health Department.

In actual practice a single report direct from a certified laboratory of a sputum positive for acid fast bacilli (even by direct examination or by "concentrate") is generally accepted as sufficient evidence to justify formal recording of the case by the Health Department, as "Pulmonary Tuberculosis, Active"; few such diagnoses must later be changed.

The attending physician, however, understandably may wish to await confirmation by one or two additional examinations in the laboratory before officially reporting a case to the Health Department, or notifying the patient, even where the latter is clearly a suspect in other ways.

There will be infrequent occasions when the attending physician feels two or more positive reports of acid fast bacilli, observed by direct examination or concentrate, to be difficult to reconcile with the total clinical picture. He will then arrange to have the acid fast organisms adjudicated in terms of pathogenicity. They are bacteriologists who insist they can identify virulent Tubercle Bacilli by culture growth characteristics alone; however, Guinea-Pig inoculation is almost universally preferred to establish this crucial point with the finality it deserves.

When satisfactory specimens are not or cannot be submitted, or when no sputum is produced, culture of gastric washings is always indicated, and should be done without delay, especially in the suspect who has a positive tuberculin test. To expedite matters gastric lavage cultures can be repeated without necessarily waiting for a report upon the first or preceding one.

While it is true that some tuberculous patients, until diagnosed and instructed, have been known to deny the production of sputum, which later with practice and training could be obtained and examined, it is not good practice to take for granted that *every* suspect, particularly among the otherwise asymptomatic clientele derived from survey, can produce sputum at will or upon request.

Accordingly, when an apparently healthy person—

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referred for diagnostic study by virtue of x-ray findings, stoutly avers that he does not produce sputum, it would perhaps seem not unreasonable to suppose that he either is unaware of its existence, wishes to conceal its presence, *or just doesn't have any;* whichever is true, gastric lavage is indicated *at once,* as a matter of routine, in the suspect whose tuberculin test is positive.

Instances have been noted where a physician, in commendable eagerness to complete an examination form, *insisted* upon being provided with a sputum specimen, over the vigorous protests of his patient. Needless to say, failure to find Tubercle Bacilli in the saliva finally submitted by the hard-pressed suspect can be misleading to the physician, and the whole experience relating to its enforced collection, fraught with confusion, if not downright exasperation, for the victim.

Like any other symptom of tuberculosis, sputum may or *may not* be present in any given patient (let alone, suspect). Normal healthy people *do not expectorate,* in the commonly accepted sense this term is used in medical parlance; otherwise it would be impossible to distinguish between people who produce sputum and those who do not (a line has to be drawn *somewhere*).

One frequently finds recorded on sanatorium charts (and in the literature) statements to the effect that "the patient has no symptoms, and his sputum is negative."—an obvious contradiction of terms we could do without! The statement would be much more realistic, were it to read "the patient has no symptoms except sputum, which is negative!" (*provided,* of course, he *still has* bona fide *sputum*!)

X-ray examination—provides the best method for detecting the *possible* presence of pulmonary tuberculosis prior to onset of symptoms; after symptoms supervene x-ray is one of the most useful of diagnostic aids. There are limitations to its effectiveness, however; for example, it has long been agreed by roentgenologists that tuberculosis cannot be diagnosed from *one* x-ray *alone.* The *most* that can be said of any *single* x-ray examination is that it is "characteristic" of the disease. On the other hand, a second basic fact relative to tuberculosis and x-ray, deserving of equal emphasis, is that "*No* one can truthfully assure a patient he does *not* have tuberculosis without at least one examination by x-ray." Physical examination is notoriously inadequate for this purpose, nor can fluoroscopic screening, even in the hands of experts, be depended upon for the detection of minimal lesions.

X-ray shadows *typical* of pulmonary tuberculosis, with or without cavity, may be caused by carcinoma, coccidioido-mycosis, histoplasmosis, non-tuberculous abscess, to mention but a few; even virus infection, though rarely responsible for cavitation, can simulate tuberculosis in other ways. Since these and other conditions *all too frequently* produce x-ray shadows indistinguishable from tuberculosis, corroborative evidence should be sought *in every instance* before *any* condition, revealed for the first time, and up to that point, *only,* by x-ray, is diagnosed as tuberculosis.

Where shadows suggest an advanced tuberculous lesion, including cavitation, expectoration is a commonly associated symptom; an almost casual inspection of but a single specimen by direct examination at times will suffice to clinch the diagnosis. "On-the-spot" confirmation in office or clinic need not, therefore, delay diagnosis of the more dangerously communicable case for longer than minutes or hours. However, failure to find Tubercle Bacilli at all, under circumstances where they should be plentiful (were the lesions tuberculous) should immediately alert one to the *possibility* of malignancy or of some other non-tuberculous condition being responsible.

Upon occasion, in the past, there have been placed upon waiting lists of Tuberculosis Sanatoria, patients with x-ray evidence so clearly indicative of tuberculosis that sputum examination was considered unnecessary. Later, upon admission, in some of these patients, routine or special sputum examinations failed repeatedly to reveal Tubercle Bacilli; the patients belatedly (relative to *first* x-ray) were directed to a general hospital; carcinoma, when found, had sometimes become inoperable.

True, carcinoma of the lung formerly was not too frequently reported and little more than supportive treatment could be offered. But today this disease entity, particularly the bronchogenic type, allegedly is many *many* times more prevalent than it was a generation ago. Moreover, modern surgery (with appropriate adjuvants) provides an almost literal "sure-cure" when diagnosed early. Indeed, malignancies can be removed successfully (without recurrence) even when the original x-ray picture suggests extensive involvement (in *most* of the *latter* instances, however, foreboding radio-opacities are found at operation to be produced, in large part, by

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atelectasis, inflammatory, and other relatively innocuous tissue reactions, not infrequently observed as secondary accompaniments).

Special position films, and *much* more important, *serial x-rays,* taken over periods of weeks or months, sometimes provide a very useful method for establishing a diagnosis where the findings can be integrated with the results of other studies, *even in the absence of laboratory confirmation.* Essentially this is a process of elimination in which "time-element" plays an important part.

There remains one type of lesion which can defy interpretation even upon serial and/or special position x-ray or indeed by any other diagnostic procedure short of surgical exploration. Reference is made to the "solitary nodule," where even the presence or absence of partial calcification does not provide a dependable clue to character or age of the underlying pathology. Upon excision these identical appearing radio-densities prove to be tuberculoma, carcinoma, or benign tumor, generally in about equal numbers, although there naturally is a substantial variation depending upon the age group reviewed. Due to their inherent malignancy potential these nodules, and for that matter, all other suspicious lesions where carcinoma is regarded to be a serious or primary contender for diagnosis *from the very beginning* (on the basis of x-ray evidence or otherwise) should be given the benefit of *very* early surgical consultation (without waiting for *report* of routine culture on sputum or gastric washings).

* * * * *

In most instances it should be possible to confirm or exclude pulmonary tuberculosis in a suspect within a matter of months (often sooner) provided appropriate standard diagnostic studies are carried out according to protocol. When these procedures prove inconclusive, the patient commonly will be referred for special examinations, such as bronchoscopy, bronchography, exploratory surgical operations, etc.

There seems to be little doubt that physical and intellectual fatigue, as well as painful emotions, decrease resistance of the body to infection; but the physiologic mechanisms which determine these important relationships are totally unknown. Despite all this ignorance, however, a belief shines as a beacon to guide our efforts. It is that the defense mechanisms of the body which promote resistance to infection appear to be closely related to the physiologic processess which make for good health—good health being here measured in the terms broadly referred to as well-being by the layman. The inner logic of the program of antituberculosis associations should lead them to become truly health associations. For it can hardly be doubted that, in final analysis, health is a positive attribute rather than merely the absence of disease. Rene J. Dubos, Ph. D., Am. Rev. Tuberc., July, 1953.

The contrast in tuberculosis mortality rates of the Japanese in Hawaii as compared with the rates in Japan is of interest. In Hawaii, the rate for the five-year period, 1918 through 1922, was 132 per 100,000 as compared with 12 in 1952. In Japan, on the contrary, the rate for 1918 through 1922 was 233 and, in 1951, the last available figure was 111. Similar differences exist in other races such as the Filipinos, Chinese, and Koreans, all having lower rates in Hawaii than those reported in their respective countries of origin. In all probability, higher living standards and better nutrition are the most important factors to account for these differences. Hastings H. Walker, M.D., Am. Rev. Tuberc., December, 1953.

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CORRESPONDENCE

Re: Conference on Problems of Medically Indigent.

Dr. Vincent W. Archer
University Hospital
Charlottesville, Virginia

I want to take this opportunity to tell you how much we appreciate your interest in the problem of indigent hospitalization as President of The Medical Society of Virginia. The recent institute that the medical society has sponsored was not only a great success, but has created much favorable comment.

All of us are deeply concerned with this problem, and the medical profession can make a great contribution with their thinking and cooperation. They have a professional and practical understanding of the problem. If we are to prevent socialized medicine, we must deal with this problem in an intelligent manner.

With kindest regards, I am

Sincerely yours,
Charles R. Fenwick

American Medical Education Foundation.

Dr. Vincent Archer, President
The Medical Society of Virginia
Charlottesville, Virginia

The A.M.E.F. meeting in Chicago on January 24 was most inspiring. Nearly every state was represented. I want to thank you for appointing me to represent the State of Virginia. Here is a condensed report of this meeting.

Dr. Louis Bauer, President of the A.M.E.F., talked to us first. He stated that over a million dollars was raised last year, and it would have been nearly two million if all the doctors' contributions had gone through the A.M.E.F. for creditation. Some states have a good record, but some states are still asleep and have a poor record because they have been slow in picking up their responsibilities. Every doctor owes something to this Foundation, for his tuition paid only one-third of this college expenses. The doctors must assume their responsibilities for endowments are not increasing. One of two things must happen. There must be more money, or the type of education must be cut down. High standards are going to be lowered if there is not adequate financial support.

Another factor not generally remembered is that some money is coming from the Federal Government now, although this is not enough to be significant. If the Federal Government takes over, private contributions will cease. But Dr. Bauer adds that in his opinion, concerted effort will make a success.

Dr. Edward L. Turner, Secretary of the Council on Medical Education and Hospitals, and Secretary of the A.M.E.F., laid stress on the fact that faculty, facility and equipment costs of medical schools are increasing. The cost now is fantastic; as compared to 1920 it has trebled. There must be a way for deserving young men to get loans and scholarships for medicine. The tuition paid covers less and less of the cost.

Mr. E. J. Ade, Director of Fund-Raising for the National Fund for Medical Education, said in part that big business is interested in medicine more and more, especially industrial and occupational medicine. There are two sides to this team now—the doctors and big business. So far the doctors are ahead, which is as it should be, and it helps because business wants to know—What are the doctors doing? American business is now the only source that can give big. The strongest bulwark that business has for free enterprise is supporting medicine. In 1951 the medical profession gave over $600,000; in 1952, over $700,000, and in 1953, $1,367,000. So the A.M.E.F. is growing. There are now over 50 national industry committees at work to promulgate the fund. It is a national problem. Industry increased its gifts by 74% in 1953. If people do not listen to their request for funds, then federal action must come.

It was again brought out that the A.M.A. pays all costs of the A.M.E.F. in addition to giving $500,000 each year. The cost in 1953, paid by the A.M.A., was over $50,000. So doctors do not give to educators 80 cents on the dollar, but their dollar goes 100 per cent towards advancing medicine.

It was brought out in Chicago that the National Fund for Medical Education distributed to medical schools from January 1, 1953, to July 1, 1953, $1,944,151. It was brought out that the A.M.E.F. raised from January 1 to December 31, 1953, $1,089,962.93. The National Fund makes a 10% deduction of money raised by the Fund to cover overhead; but, to reiterate, the A.M.E.F. makes no deductions. The number of physicians who contributed in 1953 was 17,564. Virginia had 186 contributors who gave, according to the record in Chicago, $4,854.75. The highest contributed by any

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state was by Illinois, who contributed $190,461.99. It is interesting to note that the Women's Auxiliaries contributed from January 1 to June 31, 1953, $26,-864.45.

The House of Delegates to the Illinois State Medical Society voted last year a blanket increase of $20 per member in the state dues, which money was turned over to the Foundation. Utah has recently followed the example set by Illinois. It is believed by some that this will solve the problem of organizing and maintaining active committees for the purpose of annual solicitation of the Society's membership.

I recommend wholeheartedly, from the several years' experience that I have had on this committee, that our Council seriously consider increasing our dues by $20 a year per member and that this amount be given to the A.M.E.F.

There are several reasons why I think that it is wise to add this to the State dues. One is that it is becoming embarrassing for the same members of the committee to approach the same doctors annually to get their contribution. Another reason is that there are doctors who have turned members of the committee down flatly and refused to contribute a penny, while there are other doctors making less money who contribute from $25 to $50. This is very unjust. I know of no way for the money to be raised from the doctors of the State in a fair and equitable way except by increasing the dues.

I would like to close my report by quoting from Dr. L. T. Coggeshall, Professor of Medicine, University of Chicago: "I would like to conclude this very interesting and informative discussion by saying that the proper education of doctors in this country is the core of the nation's health problem and that it is of vital concern to the American public. Medical schools are doing their utmost to maintain or actually improve the caliber of the nation's physician, but unless they have more adequate financial support there is a real danger that the ultimate result will be a dilution of the quality of medical care."

MARCELLUS A. JOHNSON, JR., M.D.
Chairman, Va. Committee for the A.M.E.F.

January 25, 1954

BOOK ANNOUNCEMENTS

Children of Divorce. By J. LOUISE DESPERT, M.D. Doubleday & Company, Inc., Garden City, N. Y. 1953. 282 pages. Cloth. Price $3.50

With 350,000 marriages in the U.S. ending in divorce each year, Dr. Despert's understanding and expert book should prove a help to many people: to those who are actually undergoing the experience of separating as well as those who are counseling with them. The material for the book has been chiefly gathered by Dr. Despert in many years of experience with the Payne Whitney Nursery School in New York.

The guiding theme of the book is well expressed by the author in the foreword: "Thus out of the actual experience of unhappy children and their parents came both the reassurance and the warning which underlie this book. The reassurance, to parents faced with divorce or already on the far side of it, is that divorce is not automatically destructive to children; the marriage which divorce brings to an end may have been more so.

"And the warning is that parents should look to their children not the day after the decree is granted, nor even the day before, but at the moment when they begin to be aware of trouble between themselves."

The author emphasizes that it is not so much the actual, but the "emotional" divorce of the parents that creates hurt and conflict in the children. Through impressive simple case histories, one comes to understand in concrete terms what kind of feelings and problems are upsetting these children. Equally concrete and sound is the advice given to parents how to help children with their conflicts, how to keep the lines of communication open between themselves and the child. Dr. Despert in this connection shows equal consideration and understanding for the troubled feelings of the parents as well as of the children.

A useful chapter is added suggesting where and to whom to turn for help if parents want counseling service for their difficulties.

A.R.F.

MENTAL HEALTH

JOSEPH E. BARRETT, M.D.
Commissioner, Department Mental Hygiene and Hospitals

The Development of Mental Health Services in Rural Areas*

The comparatively rapid growth of mental hygiene clinics in the United States has provided psychiatric facilities for many individuals who previously could not obtain such help in meeting the conflicts arising from everyday living.

In the 1952 Directory of Psychiatric Clinics published by the National Association for Mental Health there are over one thousand mental hygiene clinics listed. Most of the clinics, however, have been established in cities of 100,000 population or over. Another large group of clinics is in cities between 10,000 and 100,000 population, which serve not only the city in which they are located, but also surrounding county areas or the combined population of two or more cities.

Although the average population per square mile in the United States, a nation of about three million square miles and one hundred sixty million people, is approximately fifty people, the present clinical facilities for those people who live in areas of less than fifty people per square mile is still very limited.

The problem of extending mental health services has been dealt with in four main ways:

First: *The part time clinic or the traveling clinic.* This type of clinic has been used with varying degrees of success. A smaller community which has no mental hygiene clinic might have one day or more per week in which clinic personnel, including a psychiatrist, psychologist and psychiatric social worker will extend service to that community.

Second: *The state-wide clinic located in either the capital or a central city.* In this type the professional services are centralized, and many times people must travel extreme distances for services.

Third: *The out-patient clinic* where the psychiatric facilities are located in or subsidiary to the mental hospitals.

Fourth: *The rural clinic,* which functions much the same as a large city clinic. The main difference is that nearly all the people come from farms or communities of under 5,000 population.

The rural clinic as described in the foregoing paragraph is still quite rare, yet has many advantages which the other three methods of extending clinic services to rural communities do not have.

In the Commonwealth of Virginia there are fourteen mental hygiene clinics. Five of them are from cities in which the area served has a population of over 5,000 people per square mile. Two of the clinics are located in fairly large cities which have an average population of between 100 and 5,000 people per square mile. Three more clinics serve areas in which the average population is from 50 to 100 people per square mile. Two clinics are statewide. One clinic, the Tidewater Guidance Clinic in Williamsburg, serves an area of about 2,500 square miles with less than 100,000 population. This makes the average population less than forty persons per square mile.

The experiences in the development and growth of the Tidewater Guidance Clinic present certain light on the problems in establishing rural mental health clinics.

The need for rural mental health services exists, but perhaps the main difficulties in establishing a rural clinic should be considered.

1. *Problem of Community Interest:* In nearly every community there are citizens who see the value of having a "psychiatric first-aid station". They are able to stimulate interest in other citizens, but find it practically impossible to establish a full time clinic in their community. They may be fortunate in having available a part time clinic, a traveling clinic, or out-patient services in a mental hospital, or they may need to resort to state-wide services. If they tried to establish a full time clinic, hire a psychiatrist, psychologist and psychiatric social worker, the expense in salaries involved would be so discouraging that having a clinic would seem impossible. The only practical answer to this dilemma is to combine the interests in the whole geographic area.

2. *Development of Community Cooperation:* Establishing a common purpose for a number of communities might involve a survey of needs in the area and the proposing of a psychiatric clinic which will meet the common needs.

Professional cooperation of physicians, judges, school superintendents, county officials, and other in-

*Article prepared by W. R. Reese, Psychologist, Tidewater Guidance Clinic, Williamsburg, Virginia.

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fluential citizens must be centralized on the one common objective. This may be somewhat difficult in many rural areas where there are many local governmental units. This difficulty may be overcome by establishing a system where the clinic will be considered a part of the local facilities, even though it may be located in a community which is twenty-five to fifty miles distant from the clinic. If the main source of stimulation is local interest, the obstacles can be overcome.

3. *Problems of Organization:* Since the rural clinic is primarily for the communities which it serves, a fair basis of dividing responsibilities must be made.

In the case of the Tidewater Guidance Clinic at Williamsburg, there are twelve local cooperating units; eleven counties and the City of Williamsburg. Each cooperating unit has a representative, and the twelve representatives make up the Clinic's Advisory Board. The Board members have been concerned with obtaining support from the counties which they represent. Together the Board determines how the financial obligations can be met in a fair way to all local communities.

When the clinic was first established the counties paid proportionate amounts in accordance to the distance from the clinic. Later an analysis of the proportionate use of the clinic and the possible future potentialities of use were used in making requests for local funds.

The local government is probably one of the best sources of local funds, since the service is available to all of the people in the community. However, there are methods of getting local funds by fund raising drives of local clubs in the county concerned.

In the Tidewater Guidance Clinic the main source of local funds is voted on by the local County Boards of Supervisors. Fees may be another source of funds; however, the experience of the Tidewater Guidance Clinic has pointed out that the continuance of local community cooperation perhaps can be obtained better by making fees only supplemental and keeping the maintenance of the clinic dependent upon the local communities' cooperation. Many citizens have felt the responsibility for keeping up the clinic in much the same manner as the responsibility for keeping up their public schools.

Of course, a rural mental hygiene clinic has many of the common problems that exist in all mental hygiene clinics. In an area where there is no great concentration of population some of these problems are:

1. The distance involved in keeping appointments is not too great if there are automobiles or public transportation available, since very few communities are located more than fifty miles away. However, in some cases no public or private transportation is available for people who wish to seek help. In some cases the Department of Public Welfare representatives have found ways to furnish transportation, but there are still a great number of people for whom transportation is not available.

2. Personnel who are hired on a rural clinic staff should be aware not only of behavior of individuals, but also of the understanding of rural community living. In many cases they are needed to circulate in local community meetings, such as P.T.A. meetings or meetings of local clubs.

3. In most rural communities there do not exist such facilities as family service organizations, vocational counseling services, alcoholics anonymous, or special schools which might be found in larger communities. Therefore, in giving "psychiatric first-aid" the clinic has to consider how extensive services will be. In rural clinics the services should probably be more extensive than usual.

4. The psychiatric social worker in a rural clinic, in order cooperatively to work with physicians, schools, courts, and other agencies, has to spend more time in travel than usually expected.

5. The educational problem of interpreting services is extended because of distances involved. In some cases this may be dealt with by lectures to the various community groups, while in other cases it is extremely beneficial to have local county groups meet in the clinic's offices in order to get a better understanding of one of their local facilities.

Although there exist a number of problems in the establishment of a rural mental hygiene clinic, it perhaps has advantages over other types of rural mental health services. It is more a part of the community than a part time clinic, traveling clinic, or a state-wide clinic. It dissociates the mental hospital stigma that may be attached to a mental hospital out-patient clinic, and puts the emphasis on a preventative program.

There exist needs for more rural mental health services throughout Virginia as well as the nation. As communities develop interests which can be used to cooperate in establishing rural clinics, and as more professional staff members become available, a great stride in attacking our number one health problem will be made.

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Medical Society of Virginia Cancer Committee

Chairman, George Cooper, Jr., M. D.

Medical School Building, University, Va.

Reprints of this and preceding Bulletins may be obtained from this office

March 1, 1954

Cancer of the Vulva

Though cancer of the vulva comprises only about 4% of all female genital cancers and is rare in women under 60, its importance as compared with other surface cancers is out of proportion to its frequency.

The lymphatic supply of the vulva is bounteous and cross anastomosis plentiful. Drainage is to the inguinal and femoral nodes. Bilateral lymphatic metastasis occurs early. Compared to corresponding stages in the local development of cancer of the cervix, metastases to lymph nodes occur twice as frequently in cancer of the vulva. Fortunately, spread beyond the inguinal and femoral nodes takes place slowly. Until femoral nodes have become adherent, inguinal nodes broken down, or until the tumor has extended into the vagina, urethra, or sub-pubic space, radical surgery is therefore feasible. Radiation has little to offer because these cancers are uniformly resistant and because the region tolerates radiation poorly.

Prevention Measures

1. Cleanliness and careful attention to chronic infection, discharge, and dermatitis.

2. By far the most common type of cancer of the vulva is that which originates from the epidermis of the labium minus and the prepuce of the clitoris. In the large majority of these patients, there is a pre-existing leukoplakic vulvitis with or without kraurosis. All leukoplakic vulvar epidermis should be widely excised.

3. Senile warts and Bartholin's gland cysts should be excised. Both are precancerous lesions and Bartholin's gland tumors are more malignant than the epidermoid type.

4. Nevi of the female genitalia should be excised with a wide margin. Nevi in this location are very apt to develop into melanomata, especially during pregnancy.

5. Caruncles should be vigorously treated. Cancer of the urethral meatus occasionally develops in a neglected caruncle.

6. Most cancers of the vulva arising from the vestibular epithelium develop in a preexisting tertiary syphilitic lesion. Negroes are particularly susceptible to malignant degeneration in this type of focus of chronic irritation.

Diagnosis:

All ulcerations, including those found in syphilitics, all papillary or cauliflower tumors, and subcutaneous nodules (Bartholin's gland and sweat gland cancers usually break through their capsules only after they have metastasized) should be biopsied.

Because of their early lymphatic spread, prompt diagnosis is most necessary.

Treatment:

Bilateral vulvectomy, accompanied or followed by radical dissection of the regional lymphatics, is the treatment of choice. Taussig reports 64% of five year survivals when radical surgery is done, only 16% of five year survivals when operation is limited to vulvectomy and removal of superficial glands.

If the cancer is too far advanced for radical surgery to offer hope of cure, diathermic destruction, partial cautery excision, irradiation, or a combination of these means can do much to eliminate foul tissue and prevent pain. For pain relief only, cordotomy, in selected cases, is ideal.

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MEDICO-LEGAL NOTES

Adoption Procedure*

Because of (a) the sterility of one or both marital partners, (b) the presence of undesirable genetic traits in one or both marital partners or (c) other social, economic or medical factors, physicians are frequently called upon to advise patients concerning the advisability of adopting children. This article is presented for the purpose of acquainting the physician with some of the legal problems involved in adoption proceedings and so that the physician may guide his patient to the proper persons or agencies concerned. The physician is not authorized, and should not attempt to act as an intermediary in the adoption process.

Chapter 14, Title 63 of the Code of Virginia outlines the legal procedure involved in the adoption of a child: A petition is filed by any person who is a resident of the state, in a court of record having chancery jurisdiction in a city or county in which the petitioner resides, for permission to adopt a minor child not legally his by birth, and if also desired by the petitioner, to change the name of such child. In case of married persons, the petition is a joint petition of the husband and wife. In the event the child to be adopted is legally the child by birth or adoption of one of the petitioners, then such petitioner unites in the petition only for the purpose of indicating his or her consent thereto.

After filing of the petition, the Commissioner of the court makes, or has made, a thorough investigation, as described below, and reports in writing to the court within sixty days. Investigation is the rule, but may be dispensed with at the court's discretion under a few certain circumstances outlined by the statutes. Such investigation may be made through the Department of Welfare and Institutions, local superintendent of welfare or other welfare agency of a county or city, or through a child placement agency. A child placement agency is defined by the statutes as a person or agency licensed or legally authorized to carry out such work by the State Department of Welfare and Institutions. One such private licensed agency is the Children's Home Society of Virginia, which has offices in several of the principal cities of the state.

*Contributed by Charles W. Whitmore, M.D., LL.B., University of Virginia Hospital and School of Medicine, Charlottesville, Virginia.

The investigation includes, in addition to any other inquiries which the court may require the Commissioner to make, inquiries as to (1) whether the petitioner is financially able and morally fit to care for and train the child, (2) what the physical and mental condition of the child is, (3) why the parents, if living, desire to be relieved of the responsibility for the custody, care and maintenance of the child, and what their attitude is toward the proposed adoption, (4) whether the parents have abandoned the child or are morally unfit to have custody over him, (5) the circumstance under which the child came to live, and is living, in the home of the petitioner, and (6) whether the child is a suitable child for adoption by the petitioner. The age, culture, education, race, heritage and religion of both the child and the petitioners may be investigated in determining the suitability of the child for adoption by the petitioners.

In addition to the material noted in the preceding paragraph, the report of the Commissioner must also include his recommendation as to action to be taken by the court on the petition. A copy of the report is furnished Counsel of Record for the parties involved, if requested.

Written evidence of consent to the adoption must be filed with the petition to adopt by the following persons: (1) the child to be adopted, if he or she is 14 years of age or older, (2) by both parents, if they are both living or by the living parent if one of the parents is dead, or (3) by the mother in case of a child born out of wedlock, or (4) by one parent, if the other has deserted, neglected or cruelly abused the child or is insane, or if the consent of the other parent, for any reason deemed satisfactory by the court, is not necessary in the circumstances prevailing as disclosed by the evidence, or (5) by a child placing agency in case the parenteral rights of both parents have been terminated by any court of competent jurisdiction or by other legal means, and the child has been lawfully placed under the care and custody of the agency, or (6) by a Commissioner in any condition of fact not provided for.

The court usually provides for a probationary period of one year, during which the child lives in the home of his adopted parents, before the order of adoption is made final.

The adopted child becomes to all intents and purposes the child of the persons adopting him. The child is entitled to all the legal rights and privileges,

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and is subject to all the legal obligations of a child of such person or persons born in lawful wedlock. The natural parents of the child are divested of all legal rights and obligations with respect to the child and the child is freed of all legal obligations of obedience and maintenance with respect to them.

Many of the legal actions involving questions concerning an adoption, other than the adoption actions per se, arise over problems of inheritance. For the purpose of inheriting real or personal property, in the absence of a will, a legally adopted child inherits, according to the statutes governing the descent of real property and the distribution of personal property, from and through both the natural parents and the parents by adoption, any time after the entry of either a temporary (probationary) or final order of adoption by the court. If an adopted child dies without a will, without children surviving him, his property passes, according to the statues of descent and distribution, to those persons who would have taken had the dead child been the natural child of the adopting parents; however, any property, real or personal, derived by deed, or by gift, or by will, or by inheritance, from the natural parents, or from either of them or their kindred, and capable of identification as such, passes, according to the statutes of descent and distribution, as if he had not been adopted.

New Books.

Some of the new books received at the Tompkins-McCaw Library of the Medical College of Virginia, Richmond, are listed below. They may be had by our readers under usual library rules.

American Journal of sociology—Aging and retirement. Vol. 59, #4, 1954.
Behrens, ed.—Atomic medicine. 2d ed., 1953.
Benz—Pediatric nursing. 2d ed., 1953.
Berens & Sheppard—Abstracts on military and aviation opthalmology and visual science. 1953.
Bisch—Cure your nerves yourself. 1953.
Bowers, ed.—Surgery of trauma. 1953.
Breckinridge & Vincent—Child development. 2d ed., 1949.
Britannica book of the year. 1952.
Camp—Anatomical studies for physicians and surgeons. 1939.
Ciba Foundation—Colloquia on endocrinology. Vol. 6, 1953.
Dunphy & Botsford—Physical examination of the surgical patient.
Elliott—Zoology. 1952.
Epstein—An atlas of skull roentgenograms. 1953.
Gardiner—The principles of general biology. 1952.
Good—Probability and the weighing of evidence. 1950.
Harper—Review of physiological chemistry. 4th ed., 1953.
Jones, ed.—The life and work of Sigmund Freud. 1856-1900. Vol. 1, 1953.
Jones, ed.—Physician's desk reference. 1952.
Josiah Macy Jr. Foundation—Connective tissues. 1953.
Keynes, ed.—Blood transfusion. 1949.
Lillie's development of the chick. 3d ed., 1952.
Luria—General virology. 1953.
Main & Richardson—Physiology. 2d ed., 1953.
The medical directory. (British). 1953.
National Foundation for Infantile Paralysis—Speakers handbook. 1953.
Nichtenhauser, et al.—Films in psychiatry, psychology and mental health. 1953.
Oliver—Parkinson's disease and its surgical treatment. 1953.
Ormsby & Montgomery—Diseases of the skin. 7th ed., 1948.
Proceedings of the American academy of forensic sciences. Vol. 2, 1954.
The psychiatrist, his training and development. 1952 Conference. 1953.
Reid & Hagan—Residential treatment of emotionally disturbed children. 1952.
Roberts & Miller—Heat and thermodynamics. 4th ed., 1951.
Ross—New hearts—new faces. 1954.
Schneck, ed.—Hypnosis in modern medicine. 1953.
Singer—Vesalius on the human brain. 1952.
Smul—Respiratory diseases in allergy. 1953.
Spencer—Wonders of modern medicine. 1953.
Stevens, ed.—Administrative medicine. 1953.
Transactions of the American Surgical Association. 1954.
Transactions of the Association of American physicians. 1953.
Transactions of the section on ophthalmology. 1953.
Vitamins & hormones. Vol. 11, 1953.
Whitby & Britton—Disorders of the blood. 7th ed., 1953.
Wilson—School health services. 1953.
The world almanac and book of facts. 1954.
The year book of drug therapy. 1953-54.

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PUBLIC HEALTH

Mack I. Shanholtz, M.D.
State Health Commissioner of Virginia

Meningococcus Meningitis

The Diplococcus intracellularis meningitidis, known today as Neisseria meningitidis, was first cultivated and identified as the causative agent by Weichselbaum in 1887. Further studies through the years have shown that it is not a homogeneous species, but is separable into types that can be identified by specific agglutination reactions. This is important because of the fact that the serum used in treatment must contain the antibodies that are specific for the type of meningococci with which the patient is infected.

Meningococcic meningitis is spread through carriers as well as through persons having clinical or subclinical infections. Carriers may be transient carriers, which is usually true, or they may become chronic carriers. Meningococcic meningitis appears whenever there are concentrations of groups of people as occurred in training camps in both World War I and World War II. It occurs in epidemic waves and between epidemics it continues to develop sporadically. It is a disease found in the more humble walks of life, of crowding, of poverty and of insanitary surroundings. It is world-wide in its distribution and is found more commonly in males than in females. The age of greatest susceptibility is from ten to twenty-five years. Infection is rare after forty-five. It is seasonal in its appearance; in temperate climates the low rate is from June to November and the peak is reached between February and April.

For convenience meningococcic infections may be divided into those cases with and those without meningitis. Clinically, the infection may be divided into three stages. The first is a localized infection of the upper air passages; the second is an invasion of the blood stream producing a septicemia known as meningococcemia, or cerebrospinal fever; and the third is the metastatic stage producing localization, usually in the meninges, not infrequently in the skin, pericardium, joints, eyes, lungs or other regions. The disease may be arrested at any one of these stages or may progress from one stage to the other so rapidly that the stages seem to coexist. Consequently the division is not of great practical value either in the recognition or in the management of the disease. The most important factor in dealing with the disease is an early diagnosis. When intensive treatment is instituted within forty-eight hours of the onset, the mortality is lowest. When the treatment is delayed beyond the second day there is a rise in mortality with each succeeding day.

In army camps it was found that control of the carrier of meningococci proved effective in reducing the morbidity rate. By giving sulfadiazine to a selected group of soldiers the nasopharynx of the carrier was apparently cleared of meningococci and the development of the disease was negligible.

The treatment of the disease by chemotherapy was found to be extremely valuable. Today it appears that the treatment of meningococcic infections with penicillin is striking. Penicillin is used in combination with sulfadiazine; if the sulfonamide causes toxic effects, penicillin alone should be substituted. Antimeningococcic serum is rarely used. Chloramphenicol, aureomycin and terramycin have also been used successfully in the treatment of patients with meningococcic infections. When a case is diagnosed the contacts should be given sulfadiazine to prevent the development of secondary cases.

If signs and symptoms of adrenal hemorrhage (Waterhouse-Friderichsen syndrome) appear, the prompt administration of cortizone or adrenal cortical extract should be made in addition to the sulfonamide and penicillin therapy. In Virginia during 1953 there were 186 cases of meningococcus meningitis reported and in this group there were 39 deaths, a fatality rate of 20.96. This means that there was slightly more than one death in each five cases. We should lend our efforts to make an early diagnosis and to institute prompt and vigorous treatment, and thereby reduce this fatality rate which is considered high.

Monthly Report of the Bureau of Communicable Disease Control

	January 1954	January 1953
Brucellosis	0	6
Diphtheria	7	20
Hepatitis	541	244
Measles	975	279
Meningoccal Infections	15	29
Poliomyelitis	2	5
Rocky Mountain Spotted Fever	0	0
Streptococcal Infections (Including Scarlet Fever)	604	954
Tularemia	11	8
Typhoid Fever	2	5
Rabies in Animals	30	50

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PUBLIC RELATIONS

American Medical Education Foundation and How It Is Helping Your Medical School

THOMAS H. HUNTER, M.D., Dean

The establishment of the American Medical Education Foundation and a brief summary of its objectives were the subject of an article in the News Letter last year. In order to maintain the interest of our alumni in the excellent program of the Foundation, a few of the major advantages of it are re-emphasized below.

The main purpose of the Foundation is to raise funds within the medical profession for the unrestricted use of the nation's medical schools. Donations may be earmarked for a specific school and since all overhead costs are absorbed by the A. M. A., each dollar contributed through the Foundation will find its way to the school designated. In addition, the total of contributions to a specific medical school by alumni and friends is not considered in the allocation of undesignated funds raised by the Foundation and by the National Fund for Medical Education.

The University of Virginia School of Medicine has been benefiting from the program of the Foundation since the latter's establishment in December 1950. During the calendar year 1951, the medical school received a total of $15,000 in grants from the National Fund for Medical Education, through which the Foundation has arranged to distribute its funds. In 1952, another $20,140 was received, and it is hoped that the amount of the grants will grow each year as the Foundation becomes more widely known in the profession.

The need for financial assistance remains acute. While the problems of the privately-endowed institution are rather widely recognized, it is most important in our case that the limitations of state support be stressed. First, we are faced with strong new emotional and political competition for the taxpayer's dollar. More and more state tax monies are going into pensions and benefits for the aged and handicapped, for improving institutional care and mental health programs, to the public schools, highways and hard-pressed cities and counties. Moreover, there are a number of functions and activities conducted by the top-flight medical schools which would not normally come under state support. These include research, special lectures, scholarships, and so on. Burdened as it is with so many institutions of higher learning, the State of Virginia seemingly finds it difficult to raise the scale of faculty salaries. If our medical school is to compete with others for personnel, comparable salaries must be offered. This is now the case, and the loss of key faculty members presents a real problem.

At present a large part of the operating budget of the medical school comes from research grants, many of which are through the Federal Government. The shrinkage of these funds in the near future seems probable under the pressures for government economy, and will intensify our financial problem still further.

These dire needs can be met only with the help of the American Medical Education Foundation and alumni of the medical school, as well as greater support from the State.—*University of Virginia Medical Association News Letter*

Please send your contribution to the American Medical Education Foundation, 535 North Dearborn Street, Chicago or The Medical Society of Virginia, 1105 West Franklin Street, Richmond. Do it today!

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WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF VIRGINIA

President—MRS. K. W. HOWARD, Portsmouth
President-Elect—MRS. MAYNARD EMLAW, Richmond
Recording Secretary—MRS. LEE S. LIGGAN, Irvington
Corresponding Secretary—
MRS. LEMUEL E. MAYO, Portsmouth
Treasurer—MRS. WILLIAM C. BARR, Richmond
Publication Chairman—MRS. WM. S. GRIZZARD, Petersburg

Alexandria.

The regular monthly meeting of the Auxiliary to the Alexandria Medical Society was held on January 26th in Carter Hall of the Alexandria Hospital.

Dr. Alvin C. Wyman, secretary of the Alexandria Medical Society, and liaison officer to the Auxiliary, was guest speaker. He gave a most informative and interesting talk on the activities of the local society.

The reopening of the four year old Shoe Center was announced. This is one of the main projects of our Auxiliary. The various social agencies have been advised that needy children may again be fitted with re-conditioned shoes. This has been delayed due to the necessity of finding a repair service.

Miss Dorothy McMillan, Director of Nurses at the Alexandria Hospital, presented the student nurse who is the recipient of the full scholarship sponsored by this Auxiliary.

SARA W. ENGH
(MRS. A. ANDERSON ENGH)

Danville-Pittsylvania.

Mrs. M. H. McClintic is chairman of the Ways and Means Committee of this Auxiliary. The chief work of this committee is to raise funds for a Nurse's Scholarship fund to begin April 1954.

Mrs. F. H. McGovern is chairman of the Cancer Control Committee in the special committees of The Medical Society of Virginia Advisory Council.

This Auxiliary has donated $25.00 to the American Medical Educational Foundation for use in the Virginia medical schools. They have also joined the Virginia Council on Health and Medical Care for the year 1953-1954.

SARAH W. PRITCHETT
(MRS. DRAKE PRITCHETT)

Richmond.

The annual dinner dance planned by the Auxiliary to the Richmond Academy of Medicine for members of the Academy and their wives was held at the Commonwealth Club on Saturday, February 13th.

Mrs. G. Benjamin Carter was chairman, and she was assisted by Mrs. Richard Baylor, Mrs. Hunter S. Jackson, Mrs. William Barr and Mrs. William Grigg, Jr.

Northern Neck.

This Auxiliary held a luncheon meeting at Lowery's Grill in Warsaw on January 14th. This was the first mid-winter meeting our Auxiliary has ever held and it was necessary to discuss and dispose of business before the State board meeting in March.

Two new members were introduced—Mrs. Spotswood Stoddard, White Stone, and Mrs. H. H. Wescott, Irvington.

RUTH L. GRAVATT

Newport News-Warwick.

A luncheon meeting of the Auxiliary to the Newport News-Warwick Medical Society was held on January 27th at the home of Mrs. Thomas N. Hunnicutt, Jr., in Huntington Heights. The president, Mrs. Barnes Gillespie, presided.

Mrs. Bernard H. Raymond, Norfolk, chairman of the Nurse Recruitment of the Woman's Auxiliary to The Medical Society of Virginia, was guest speaker. She was introduced by Mrs. Paul Hogg. Mrs. Raymond outlined the progress of the nurse recruitment program of the Norfolk Auxiliary. Three Future Nurses' Clubs have been organized in Norfolk High Schools in the past two years. Great emphasis

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is being placed on nurse recruitment by national, state and local auxiliaries.

BESSIE G. AMORY
(MRS. GUY C. AMORY)

The Petersburg Auxiliary

To the Fourth District Medical Society had its January meeting in the conference room of the Petersburg Hospital with Mrs. Kirby T. Hart, Jr., vice-president, presiding in the absence of Mrs. Clyde Vick, Jr., president.

Mrs. Garnett Link and Mrs. Francis Payne, Jr., were appointed to be in charge of Doctor's Day. They decided to send each doctor a red carnation for the occasion.

The semi-annual rummage sale is to be held this year, April 22nd and 23rd, with Mrs. E. Palmore Irving in charge.

Contributions were made to the Leigh-Hodge-Wright Memorial Fund and also to the March of Dimes.

Mrs. John E. Hamner gave a report on the nurse recruitment project which is to be discussed more fully at the next meeting.

MRS. JOSEPH P. WHITTLE

Norfolk.

Mrs. J. R. St. George, president, presided at the January meeting of this Auxiliary, at which time it was voted to be responsible for obtaining 125 pints of blood the first week of March for the Red Cross Blood Center.

Mrs. John Rosenthal, membership chairman, announced the following new members since January 1st: Mrs. Henry Rogers, Mrs. William F. Murphy, Mrs. William C. Andrews, Mrs. Earl Kerpelman, Mrs. Harold Goldman, Mrs. George Rector, and Mrs. Vernon Cofer.

The Health Education committee was in charge of the program. Mrs. James S. Kitterman introduced Mrs. Lucy Mason Holt, vice-president of the Virginia Society for Crippled Children and Adults and president of the local chapter. She discussed the work of the Society and stressed the needs of and the progress made in the local Cerebral Palsy Center.

In observance of Doctors' Day, the Auxiliary entertained the members of the Norfolk County Medical Society with a buffet dinner and dance at the Norfolk Yacht and Country Club on February 10th. At the time, the Auxiliary presented the Society a blackboard to be used in their library. Mrs. C. C. Smith was general chairman, assisted by Mrs. T. Elmore Jones.

HELEN V. KRISCHER
(MRS. M. I. KRISCHER)

The American Medical Education Foundation

Was organized in 1949 to help secure private financial support for medical schools. Today, with rising costs of modern training, the schools are in a precarious financial condition.

A physician's tuition pays only twenty-five per cent of the actual cost of his education. The rest of his expense is met by the State, endowment or gifts. These sources are now inadequate to meet present costs. Unless the schools receive some additional funds, they will have to lower their standards or accept federal aid in amounts that might lead to government domination.

Your help is needed! We would like for every Auxiliary to be a contributor.

ELIZABETH BARR, *State Chairman,*
AMERICAN MEDICAL EDUCATION FOUNDATION

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EDITORIAL

Editorial Board

DURING the terminal months of his illness, Dr. Rucker's interest in the welfare of the Virginia Medical Monthly never fagged. His zeal for preparing editorials in the face of extreme suffering was amazing. His special capacity for preparing subject matter of historical interest cannot easily be replaced. Dr. Rucker was a man of great literary ability and unbiased vision.

To fill the gap left by Dr. Rucker's death, the President of The Medical Society of Virginia has appointed an Editorial Board which will operate as a subcommittee of the Publication Committee, incorporating the latter members into its body. Two objectives were sought: first, to seek out those with experience in the affairs of the Monthly, and secondly, to represent adequately the professional and scientific interests of the Society. The Editorial Board will prove of value in so far as it is active and wieldy. However, numerical restriction on its membership has not been imposed.

In planning the editorial section, the Board will select appropriate subjects for editorializing and choose well qualified individuals to prepare the editorials on these subjects.

Future issues of the Monthly will contain a calendar of coming state and nation-wide events of interest.

Consideration is being given to improvement in the quality of reproductions if the cost does not prove prohibitive.

Suggestions from members of the Society concerning potential editorial material or concerning any of the various features of the Monthly will be greatly welcomed.

SOCIETIES

The Warwick-Newport News Medical Society

Met at the James River Country Club, Newport News, on January 12th. Dr. Cary G. Suter, Department of Neurology and Psychiatry, University of Virginia, spoke on "Modern Trends in Treatment of Epilepsy".

At the meeting on February 9th, Dr. Richard J. Ackart, Director, Virginia Medical Service, Richmond, spoke on "Recent Developments in Blue Cross and Blue Shield Programs".

New officers for 1954 are: President, Dr. William A. Read; vice-president, Dr. W. Ward Anderson, Jr.; and secretary-treasurer, Dr. F. Ashton Carmines.

Tri-County Medical Society.

The regular monthly meeting of this Society was held in Windsor on January 26th, with Dr. T. A. Morgan, Franklin, presiding.

Dr. George Carroll, Suffolk, presented a paper on "Causes of Sudden Deaths in Infants."

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The following officers were elected: President, Dr. W. Holmes Chapman, Jr., Suffolk; vice-president, Dr. J. A. Payne, III, Sunbury, N. C.; and secretary-treasurer, Dr. L. J. Stetson, Suffolk. Drs. T. A. Morgan, Franklin, F. I. Steele, Windsor, and J. M. Habel, Jr., Suffolk, are members of the Executive Committee.

Mid-Tidewater Medical Society.

At the regular meeting in West Point on January 26th, under the presidency of Dr. H. L. Shinn, Hallieford, a report of the Medical Service Committee of The Medical Society of Virginia was given by Drs. Charles M. Caravati and Thomas Murrell, Jr., both of Richmond. Dr. Russell Buxton, Newport News, spoke on Cancer of the Bowel, and there was a Panel on Geriatrics with Dr. Robley D. Bates, Newtown, as moderator. Discussants were Drs. William Johns, George Fultz, William Jordan, and Wellford Reed, all of Richmond.

Buchanan-Dickenson County Medical Society.

At the regular meeting of this Society, held at Grundy on January 20th, the following officers were elected: President, Dr. W. A. Cover, Big Rock; vice-president, Dr. Lewis Aaron, Grundy; and secretary-treasurer, Dr. James S. Richardson, Grundy.

Danville-Pittsylvania Academy of Medicine.

New officers of the Academy are Dr. John W. Hooker, president, and Dr. Jefferson D. Beale, secretary. Both are of Danville.

Fredericksburg Medical Society.

At a meeting on January 19th, the following officers were elected: President, Dr. Thomas B. Payne; vice-president, Dr. Henry Bernstein; and secretary-treasurer, Dr. E. Lee Earnhardt.

Albemarle County Medical Society.

Dr. E. C. Drash was elected president of this society at the January meeting, and Dr. Cary Moon is secretary.

Lynchburg Academy of Medicine.

At the regular monthly meeting of the Academy, held on January 11th, the following officers were elected: President, Dr. John R. Saunders; president-elect, Dr. A. D. F. White; vice-president, Dr. Frank R. Whitehouse; and secretary, Dr. Frank N. Buck.

The Bedford County Medical Society

Has elected the following officers for 1954; President, Dr. J. G. Jantz; vice-president, Dr. W. G. Hardy; and secretary-treasurer, Dr. W. V. Rucker.

Virginia Peninsula Academy of Medicine.

At the regular meeting held on January 20th, Dr. George Cooper, University of Virginia, spoke on "Limitations of Roentgen Diagnosis."

Dr. Chester D. Bradley is president of this society and Dr. W. T. Watkins, Jr., secretary-treasurer. Both are of Newport News.

Fairfax County Medical Society.

A meeting of this Society was held on January 12th in the office of Dr. Robert C. Hunt, Falls Church. The guest speaker was Dr. William Dolan, Chief of Laboratory Services at the Arlington County Hospital, his subject being Clinical Application of Newer Laboratory Procedures.

The Richmond Academy of Medicine,

Section on The History of Medicine, held its annual meeting on February 9th. The program was as follows: "Changing Concepts in American Medicine Over Three Centuries" by Dr. Richard H. Shryock, Institute of the History of Medicine, Johns Hopkins University; and "Richmond Hospitals—1861-1865" by Dr. A. L. Herring, Jr., Richmond.

Smyth County Medical Society.

Officers of this Society for the year 1954 are: President, Dr. Joseph J. Eller, Marion; vice-president, Dr. Walter Schiff, Marion; and secretary-treasurer, Dr. James A. Soyars, Saltville.

NEWS

"Southern AMA Special".

Physicians of the Medical Association of Georgia are arranging, through the Moyers Travel Bureau of Atlanta, a scenic 8,000 mile tour—20 days of educative vacation with five days in San Francisco for the AMA meeting—and physicians in other states are invited to join them. This special train will leave from Atlanta on June 13th and will stop in New Orleans, San Antonio, El Paso, Juarez, Grand Canyon, Los Angeles, and then on to San Francisco

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for the meeting. It will leave San Francisco on June 25th and go to Seattle, Vancouver, Lake Louise and Banff, arriving back in Atlanta on July 2nd. The rate for this all-expense tour will be $445.00 and anyone interested should contact the Moyers Travel Bureau, 34-38 Peachtree St., Atlanta, Ga.

Richmond EENT Society.

Officers of this Society are Dr. L. B. Sheppard, president, and Dr. Charles N. Romaine, secretary-treasurer. Meetings are held at the Commonwealth Club on the first Tuesdays of January, March, May, and October.

Dr. Austin I. Dodson,

Richmond, was guest speaker at the International Medical Association of Southwest Texas in San Antonio, January 26-28. He gave three lectures—Uretero Pelvic Obstruction; The Relationship of Surgical Diseases of the Kidney to Hypertension; and Injuries of the Bladder and Urethra.

Virginia Society for Pathology and Laboratory Medicine.

At a recent meeting the following officers were elected for 1954: President, Dr. S. Miles Bouton, Lynchburg; vice-president, Dr. Edward Levy, Norfolk; and secretary-treasurer, Dr. George J. Carroll, Suffolk. Dr. Arnold Rawson, Norfolk, was appointed counselor.

The Virginia Surgical Society,

At a meeting at the Homestead, Hot Springs, on January 16th, re-elected Dr. Randolph Hoge, Richmond, as president. Dr. C. B. Morton, Charlottesville, was named vice-president; Dr. R. L. Payne, Jr., Norfolk, secretary; and Dr. W. R. Hill, Richmond, treasurer. The Society's council will consist of the officers and Drs. R. P. Bell, Jr., Staunton, E. P. Lehman, Charlottesville, E. M. Horgan, Winchester, and I. A. Bigger, Richmond.

Dr. W. R. Whitman, Jr.,

Has been appointed Assistant Chief Surgeon of the Norfolk and Western Railway Company with office at Roanoke.

Richmond Academy of General Practice.

Dr. W. Linwood Ball was installed as new president at the January meeting. Dr. F. Elliott Oglesby is president-elect; Dr. Harold I. Nemuth, vice-president; Dr. R. S. Faris, secretary; and Dr. J. C. LeFon, treasurer. Drs. Irwin Rifkin and George G. Ritchie, Jr., were installed as directors for two-year terms.

Dr. Herbert A. Porter,

Formerly of Boisseau, has located at Pocahontas for the practice of medicine.

Seminar and Conference on Cancer Cytology.

Dr. Joseph S. Stewart, Chairman of the Third Annual Seminar and Conference on Cancer Cytology to be conducted by the Cancer Institute at Miami, Florida, announces that the conference will be held on April 21-24, inclusive.

This year the conference will bring together several leading authorities on cancer from this country and abroad. The last day will be devoted to a special session for medical practitioners, who will visit the Institute to see demonstrations on the taking and preparation of cytodiagnostic tests for cancer of many types, with special sessions devoted to cancer of the uterus, breast, prostate, lung and stomach.

Full information may be obtained from Dr. F. Ernest Ayre, Director of the Institute, 1155 N. W. 14th Street, Miami, Fla.

Dr. Victor C. Welch,

Effective March 1st, will be located at the Veterans Administration Hospital, Perry Point, Md. He has recently been with the E. I. DuPont de Nemours Company at Waynesboro.

Postgraduate Course for General Practitioners.

The School of Medicine of the University of North Carolina announces a three-day intensive postgraduate medical course designed primarily for general practitioners to be held at Chapel Hill April 13, 14, 15. The course is similar to the one held last year and is entitled "Implications of Newer Diagnostic and Therapeutic Techniques." Physicians will again be given an opportunity to participate in the selection of specific topics for the program.

Conference on Industrial Health.

A conference on Industrial Health will be held at N. C. Memorial Hospital, Chapel Hill, N. C. on March 12, 1954. The conference is designed primarily for physicians who are providing part-time health and medical services to industrial establishments. The conference will be sponsored by the School of Medicine of the University of North Carolina in cooperation with the Committee on Industrial Health of the North Carolina Medical Society.

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The Southeastern Allergy Association

Will hold its annual meeting at the Dinkler-Plaza Hotel, Atlanta, Ga., March 25-27. Dr. W. Lindsay Miller, Gadsden, Ala., is president, and Dr. Katharine Baylis MacInnis, Columbia, S. C., secretary-treasurer.

American Geriatrics Society.

The 11th Annual Meeting of this Society will be held at the Fairmont Hotel in San Francisco, just preceding the meeting of the American Medical Association. The scientific sessions will begin on the afternoon of June 17th and continue through the morning of the 19th.

The meeting will be open to all members of the American Geriatrics Society and to physicians and other scientists who are interested in the field of geriatrics. The program will cover many aspects of geriatric medicine, and there will be panel discussions on subjects such as recent developments in cardiology, methods of determining operability in older patients, and the relation of industry to geriatrics.

Dr. Lawrence W. Kinsell, Highland Alameda County Hospital, 2701 Fourteenth Avenue, Oakland 6, California, is in charge of local arrangements.

American Goiter Association.

The 1954 meeting of this Association will be held at the Somerset Hotel, Boston, Massachusetts, April 29, 30 and May 1. The program for the meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland.

Further information may be secured from Dr. John C. McClintock, secretary, 149½ Washington Avenue, Albany, N. Y.

Pan-Pacific Surgical Association.

Doctors are cordially invited to attend the Sixth Congress of the Pan-Pacific Surgical Association to be held in Honolulu, October 7-8, 1954, and are urged to make arrangements as soon as possible if they wish to be assured of adequate facilities.

An outstanding scientific program with over 100 leading surgeons, including sessions in all divisions of surgery and related fields, promises to be of interest to all members of the profession. An extensive social program is being developed for the doctors' families.

For further information, please write to F. J. Pinkerton, M. D., Director General, PAN-PACIFIC SURGICAL ASSOCIATION, Suite Seven, Young Building, Honolulu, Hawaii.

Private Clinic

Near Richmond desires part-time services of specialists in general surgery, EENT, radiology, obstetrics and gynecology, internal medicine, pediatrics, neurology and psychiatry, urology and dermatology. Full time services of one general practitioner also desired. Give full biography in first letter. Reply to Box 50, % Virginia Medical Monthly, Box 5085, Richmond 20, Va. (*Adv.*)

Location Wanted.

Young married general practitioner desires to relocate in eastern or central Virginia. Five years experience; two years in U. S. Navy and three in small town practice, with work predominantly in obstetrics. Prefer small city or town or association with older practitioner who anticipates retirement. Write "Location", care the Monthly, P. O. Box 5085, Richmond 20, Va. (*Adv.*)

OBITUARIES

Dr. Everett Idris Evans,

Richmond, internationally known expert on burn surgery and traumatic shock, died in Washington, D. C., on January 14th following a heart attack. He was a native of Norfolk, Nebraska, and forty-four years of age. Dr. Evans received his Ph.D. in 1935 and his medical degree in 1937 both from the University of Chicago. He joined the staff in 1942 and had been professor of surgery at the Medical College of Virginia and director of the surgical research laboratories since 1948. Dr. Evans' exhaustive research into care and treatment of burns carried him to the University of Edinburg in Scotland and the Royal College of Surgeons in London as a visiting lecturer in 1952. He was principal investigator for the research and development board of the Army Surgeon General's office and also served as surgical consultant to the Atomic Bomb Casualty Commission,

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Far East Command (Japan), and was chairman of the National Research Council's committee on burns. Because of Dr. Evans' studies on traumatic shock during World War II, the Army began treating shock with whole blood instead of plasma. He was awarded a certificate of appreciation by both the Army and the Navy in 1948 for his contribution to scientific research.

Dr. Evans was a member of Alpha Omega Alpha and Sigma Xi, honorary medical fraternities. He held membership in many medical organizations, both national and international, and had been a member of The Medical Society of Virginia for ten years. His wife and three children survive him.

Dr. Charles Howard Baker,

Chilhowie, died at the home of his son in Donaldsonville, Georgia, on January 12th. He was seventy-nine years of age and a graduate of the University of Virginia, School of Medicine, in 1900. Dr. Baker began his practice in Grahams Forge but later moved to Chilhowie, where he practiced for thirty-one years. He had been retired for about sixteen years. Dr. Baker was a Life Member of The Medical Society of Virginia, having joined in 1900.

Dr. Nathaniel Fulford Rodman.

Well-known physician of Norfolk, died January 14th, having been in failing health for more than three years. He was a native of North Carolina and sixty-three years of age. Dr. Rodman graduated from the Jefferson Medical College in 1914 and had practiced in Norfolk for more than thirty years. He had been a member of The Medical Society of Virginia since 1916. His wife, a son and two daughters survive.

Dr. William Oscar Neal,

One of the oldest practicing physicians in his section died at his home at Chatham Hill, January 8th, death being due to cerebral hemorrhage. He was seventy-seven years of age and had practiced in that county for fifty-two years. He attended Emory and Henry College and graduated in medicine from the University of Virginia in 1901. He was a Life Member of The Medical Society of Virginia and also of the American Medical Association. He had been a member of the Tazewell Lodge A.F. & A.M. for forty-five years. His wife, two sons and several grandchildren survive him.

Dr. Robert Alexander Warren,

Hot Springs, died December 19th after an illness of several years. He was eighty-one years of age and received his medical degree from the University of Maryland in 1907. Dr. Warren had been a member of The Medical Society of Virginia since 1909.

Dr. J. Walker Jackson,

Machipongo, died January 14th, at the age of sixty-nine. He was a graduate of the former University College of Medicine, Richmond, in 1909. Dr. Jackson had been a member of The Medical Society of Virginia for forty years. His wife and a son survive him.

Dr. Julius Dreher Willis,

Roanoke, died in his office following a heart attack on January 29th. He was sixty-seven years of age and graduated from the Medical College of Virginia in 1909. Dr. Willis had practiced in Roanoke for more than forty years. He had been a member of The Medical Society of Virginia since 1909.

Dr. Horace G. Longaker,

Newport News, died February 7th at the age of sixty-one. He was a graduate of the Jefferson Medical College in 1915 and was director and chief surgeon of the Newport News Shipbuilding and Dry Dock Company for thirty years, having retired four years ago. Dr. Longaker was a member of The Medical Society of Virginia for twenty-three years. His wife and two sons survive him.

Dr. Milton Buell Coffman,

Richmond, died February 6th, following a heart attack though he had been in ill health for sometime. He was sixty-nine years of age and a graduate of the Hahnemann Medical College in 1906. Dr. Coffman began his practice in Richmond as a general practitioner. He served during World War I with the Twelfth Royal Irish Rifles and was awarded a British Military Cross. Upon his return to Richmond, he specialized in ear, nose and throat. Dr. Coffman had been a member of The Medical Society of Virginia for six years. His wife and a daughter survive him.

Dr. Howard Calvin Cain

Died at his home in Schuyler on January 13th at the age of fifty-three. He was a graduate of the Medical College of Virginia, following which he practiced for some time at Orange. Dr. Cain was formerly a member of The Medical Society of Virginia. A son survives him.

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Dr. William Tate Graham.

WHEREAS God, in his infinite wisdom, has called to his eternal reward William Tate Graham on the 13th of December 1953, and

WHEREAS the Richmond Academy of Medicine is deeply bereaved at the passing of this exemplary member

BE IT RESOLVED that in Dr. Graham's death, the Academy has lost a sincere friend, a loyal and true member; one of the "old school" whose contagious personality and keen interest will be greatly missed, and

THAT in being Virginia's and Richmond's pioneer orthopaedic surgeon who settled here in 1913, and who was appointed to the Professorship of Orthopaedic Surgery of the Medical College of Virginia in that same year, which was the year of consolidation of the two medical schools of this city, and whose keen interest in crippled children caused him to be known through the State and the South, and through such devotion founded the Crippled Children's Hospital of this City

THAT whose interest in prevention of disease, as well as his skill as an orthopaedic surgeon caused him to be appointed to the Virginia State Board of Health in 1923, and who became its President in 1926, which position he held until his death.

Dr. Graham was a man with a warm personality, a gifted and beloved teacher, a conservative and devoted surgeon, one endowed with a keen sense of humor, unsurpassed patience which served him so well in his chosen specialty, and so beautifully exemplified by his attitude during his own long and painful illness. He had a deep love of people with whom he always made friends, a spiritual devotion that was unique and exemplary, and in the passing of such a striking person, be it assured that he will be greatly missed.

THAT we extend to his family our deepest sympathy in their loss, and

BE IT FURTHER RESOLVED that this resolution become a part of the permanent records of the Academy of Medicine, that they be published in the *Virginia Medical Monthly*, and a copy be sent to his family.

JAMES T. TUCKER
JOHN P. LYNCH
H. PAGE MAUCK, *Chairman*

Dr. John Fulmer Bright

Was born in Richmond November 17th, 1877. His father, Dr. George H. Bright, an active practitioner of this City for many years, was a native of South Carolina and a graduate of Jefferson Medical College in the class of 1858. His mother, Mary Davies Bright, was a lineal descendent of the noted Presbyterian devine Samuel Davies.

From the public schools of Richmond Dr. Bright entered the Medical College of Virginia and, from that institution, received the degree of M. D. in 1898. He began practice immediately and the following year became connected with the College as instructor in anatomy which, at that time, was one of the most important subjects in the curriculum. In 1906 he was made head of this department, a position he held until 1911, when he was succeeded by a full time teacher. Students of that day will recall Dr. Bright as an outstanding figure in a group of impressive personalities that made up the faculty. Endowed with a phenomenal memory and a remarkable facility of expression, his lectures and demonstrations illuminated a subject that was often otherwise dull, while his genial manner and ready wit endeared him to students and colleagues alike. Since his resignation in 1911 he has been Professor Emeritus of Anatomy.

Though he continued in practice for some twenty-four years, Dr. Bright's talents and interests led him into other fields. Entering the National Guard in 1907 as a medical officer, in 1921 he became Commanding Officer of the first Virginia infantry and retired in 1941 with the rank of Brigadier General. In 1922-1924 he served in the Virginia House of Delegates and, in 1924, was elected Mayor of Richmond. This post he filled with great distinction for sixteen years, a period longer than that of any other mayor in the City's history. During this tenure of public office he came to be regarded not only as an able and gracious administrator but also as one of the most gifted speakers of his generation. In 1941 he became assistant coordinator of the State Defense Council and, in 1942, director of the Federal Office of Price Administration. Since 1950 he had been medical advisor to the State Industrial Commission. In each of these positions his activities were characterized by a deep sense of public duty and forthright espousal of the course he thought to be right, regardless of whether or not it was popular. There was never any doubt as to where he stood on the issues with which he was confronted.

Dr. Bright became a member of the Academy in 1901 and, for many years, took an active part in its sessions. After retiring from practice he retained his membership and often attended meetings. In legislative matters his aid and counsel were frequently sought and always cheerfully given. Though his health had been failing for some time his mind remained clear and he was able to attend to his duties and take part in public discussions until shortly before his death which occurred suddenly on December 29th.

BE IT THEREFORE RESOLVED: That in the death of Dr. Bright, the Academy has lost one of its most conspicuous and talented members and the City one of its most useful and devoted citizens. Though his distinctions were largely won in fields other than medicine, the profession claims him with pride and it is with deep sorrow that his colleagues record his passing.

BE IT FURTHER RESOLVED that a copy of this resolution be spread on the minutes of the Richmond Academy of Medicine, a copy sent to the members of Dr. Bright's family, and a copy forwarded to the *Virginia Medical Monthly*.

E. T. GATEWOOD
C. L. OUTLAND
J. M. HUTCHESON, *Chairman*

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